DOCUMENT RESUME

ED 034 059 VT 009 696

TITLE	Community Mental Health and the Psychiatric Foundation.
INSTITUTION	California Society of Psychiatric Technicians, Sacramento.; National Association of Psychiatric Technology, Sacramento, Calif.
Pub Date	Apr 69
Note	140p.; Presentation made at the Joint NAPT-CSPT Convention Institute (Annual, San Francisco, Calif., Oct. 11-13, 1968).
Available from	National Association of Psychiatric Technology, 11th and L Building, Main Floor, Sacramento, California 95814 ($1.75)
EDRS Price	EDRS Price MF-$0.75 HC-$7.10
Descriptors	Community Health Services, *Health Occupations Education, *Health Personnel, *Health Services, Junior Colleges, *Mental Health, Mental Health Programs, Psychiatric Aides, Psychiatric Hospitals, State Legislation
Identifiers	California Society of Psychiatric Technicians, Community Mental Health, National Association of Psychiatric Technology, New Careers, Psychiatric Technician

Abstract

The National Association of Psychiatric Technology (NAPT), a non-profit organization, is the outgrowth of local and state organizations of psychiatric attendants, aides, and technicians who had banded together to improve their knowledge and skills and to demonstrate their competence to assume greater responsibilities in the care and treatment of the patients in the state hospitals for the mentally ill. NAPT's objective is to foster the advancement of the middle-level professional in mental health through the development of open-ended career ladders and educational programs. Convention-institute presentations include: "The Effect of Cutbacks on Mental Health Programs" by Alan Short, "The Job Role of the Mental Health Technician" by Harold I. McPheeters, "The New Era in Medicine" by Earle M. Marsh, "Mental Health Training in Junior Colleges" by Walter R. Kersey, "The Purdue Program for Mental Health Workers" by John E. True, "Psychiatric Technology and Mental Health Manpower Problems" by Willis H. Bower, "The Mental Health Technician: Maryland's Design for a New Health Career" by Robert M. Vidaver, "The New Careers Program" by Jacob R. Fishman, and "Community Mental Health Manpower Needs" by Sylvia Marshall. (JK)

Community Mental Health and the Psychiatric Technician

Institute Presentations on Pioneer Work in Developing New Roles and Training Programs for Middle Level Professionals in Mental Health to Meet National Manpower Needs.

ED034059

PURDUE TRAINS MENTAL HEALTH WORKERS

MARYLAND'S DESIGN FOR A NEW HEALTH CAREER

NEW CAREERS PROGRAM IN MENTAL HEALTH

CALIFORNIA'S SEARCH FOR COLLEGE PROGRAM FOR PSYCHIATRIC TECHNICIANS

ROLE OF COMMUNITY MENTAL HEALTH WORKERS

THE NEW ERA IN MEDICINE

VT009695

National Association of Psychiatric Technology
and
California Society of Psychiatric Technicians

PRICE $1.75

ED034059

Community Mental Health
and the
Psychiatric Foundation

Presentation made at the
Joint Annual NAPT-CSPT
Convention Institute in
San Francisco, California
October 11-13, 1968

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Published under the Auspices
of the
National Association of Psychiatric Technology
and the
California Society of Psychiatric Technicians
1127 - 11th Street, Sacramento, California 95814

April, 1969

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NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY

CALIFORNIA SOCIETY OF PSYCHIATRIC TECHNICIANS

Non-profit organizations devoted to the professional development and recognition of middle level workers in mental health as a means for providing comprehensive care, treatment, rehabilitiation or habilitation of the mentally ill, the emotionally disturbed and the mentally retarded.

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PREFACE

This publication is the second of its kind for the National Association of Psychiatric Technicians. Our first publication, "Mental Health Manpower and the Psychiatric Technician," was so well received across the country by individuals and organizations working in the field of mental health that we were encouraged to publish our 1968 convention-institute presentations. We are happy to share with you some of the ideas of exceptional men in mental health training, personnel utilization, and mental health legislation and organization.

The theme of the 1968 convention-institute in San Francisco, "Community Mental Health and the Psychiatric Technician" is but another aspect of the ever-present problems of patient needs and how best to organize manpower and community resources to meet these needs. These problems will be present for many more years. However, it is hoped that the present plans and programs for training and using new classes of mental health workers, and for new roles and responsibilities for established classes of workers, will help banish some of these chronic bugaboos.

The changes in treatment concepts and the emergence of rehabilitation as the process and the goal have been accompanied by physical and functional changes. The place of care, treatment and rehabilitation shifts from the state hospitals to the local community facilities. The psychiatric technicians and others on the mental health therapy team have assumed new roles. Above all the patient has been encouraged to see himself and his problems in a new light. His expectations are more optimistic. His attitudes and that of his helpers are more positive. He has begun to feel that he can learn to better control the forces that are important in his daily life.

The changes in roles and functions that have occurred in the hospitals have been made without too many changes in the classes of employees treating and rehabilitating the patients. The hospitals have had augmentation of their therapeutic staff with specialists in vocational rehabilitation and activity therapies, and have provided higher levels of responsibility for established classes of employees. However, outside the hospital, in the community mental health programs, new classes of workers have been developed to meet the special requirements for assisting the patient and his family in his daily social, educational, vocational, and recreational living.

These new classes of workers are designated as mental health assistants or technicians or as community mental health technicians. In some instances comprehensive career structures have been set up, as in Illinois, for a mental health worker career series. The series include employees engaged in a wide variety of therapeutic functions involving the care, treatment and rehabilitation of the mentally ill and mentally retarded persons, as well as the prevention or control of mental illness or mental retardation. The mental health workers are trained as generalists. The job specifications are written to provide for maximum flexibility in the horizontal mobility of staff.

The message that comes through insistently from these presentations is the breath of the changes taking place in the health occupations. It is to be the largest occupation in the country within a year or so. Its growth is necessary but it can only be sustained by qualified workers at all levels.

One of the most significant changes is the acceptance of the idea that the mentally ill and the mentally retarded must have our fullest attention and concern as human beings with needs that are special yet similar to our own. Their rehabilitation depends in large measure on the expectations we have for them and the programs we provide to make these expectations materialize.

The expectations and opportunities we extend the patients and clients should be no less for those who elect to work with them. The mental health worker whatever his particular designation, must have the prospect of an attractive and rewarding career that will permit him to develop his capabilities and interests fully. He must have these opportunities if he is to make the maximum contribution to the treatment and rehabilitation of his charges. The emphasis is on the development of middle level professionals because the greatest shortages are at that level. However, the middle level must be part of a career ladder that gives entry to the underprivileged individuals whose potentials are too often stifled or destroyed in dead-end jobs, unemployment or underemployment.

If this publication helps advance this message we will feel well rewarded.

William L. Grimm
Executive Director

INTRODUCTION

The psychiatric technician finds himself in an uncomfortable yet challenging period of transition. He grew up and came of age in the large, state mental hospitals and has witnessed the gradual penetration of new, more optimistic and more humane attitudes towards the institutionalized patients. He has gradually changed his role from an attendant or custodian of the mentally ill and mentally retarded to that of a motivator. Now that the walls, which kept the patient isolated, out of sight and forgotten, are being breached, the psychiatric technician finds that he too, like his patients, must face a new world of a faster tempo. Like his patients he is uncomfortable and somewhat apprehensive about making the change in setting and role, but the call for a greater, more responsible part in community mental health is irresistible and he knows he must prepare for it.

The changes in treatment concepts, in treatment roles and treatment objectives affect all mental health personnel and facilities across the nation, although the degree and rate of change varies greatly from place to place. In some hospitals and states there is little to distinguish present practice and roles from that existing prior to Pearl Harbor. In other places the efforts of men who feel the urgency for change are reflected in imaginative research and treatment programs and new organizational structures. Some of the men whose presentations appear in this publication were among the pioneers in these new developments in mental health.

We speak of trends in social, economic and political development while recognizing that they can be stopped and reversed. The past history of mental health treatment in the United States should make us cautious of the "inevitable" success and dominance of the "right" concept, idea, technique or procedures. The current, newer concepts for treating and rehabilitating the mentally ill seem very similar to those described as "moral treatment" in the first half of the last century. This was interrupted by the Civil War and social and economic changes which followed it. Our present optimistic attitude toward the mentally ill and mentally retarded may be on a thin foundation if Doctor I. Sanbourne Bockovern is right in his comment expressed in "Moral Treatment in

American Psychiatry": "It would appear that the way a society treats its mentally ill is but a manifestation or particular instance of the way the members of that society treat each other."

But for the men who recognize the growing demands and expectations for more comprehensive mental health care and are prepared to do battle with severe manpower shortages and training programs, there is no turning back despite carefully nurtured official inertia or opposition. The attack on the old and the new problems come from many sources. Their purposes may not always be identical nor their efforts coordinated, yet somehow they converge upon common problems and become allies. These allies include the proponents of new careers in human services, including mental health, developers of community college training programs for mental health technicians, and advocates of legislation for comprehensive community mental health programs. They include also the researchers and implementers of new programs and new roles in treating, rehabilitating or habilitating those persons suffering from mental, emotional or behavioral disorders, or mental retardation.

Typical of the implementation of the community mental health concept is the story of California. State Senator Alan Short of California was instrumental in securing the passage in 1957 of the State's Community Mental Health Services Act (Short-Doyle Act). At that time the purpose was strikingly new: to encourage the treatment of the patient in the home community, in close collaboration with the family doctor, local general hospitals, and other local health and welfare resources. It was a means to promote decentralization of administrative services. It manifested respect for the dignity and freedom of the individual patient. Significant of the new trends it underwrote services not only to treat the mentally ill and deficient but also to prevent psychiatric disorders and to conserve mental health.

The guiding principles of the Act encompassed:

1) Federal, state and local responsibility for preventive and therapeutic services.

2) Local autonomy in initiative and administrative services.

3) Flexibility of program standards to meet local conditions.

4) Individual volition to accept services.

5) Equal opportunity to share services.

6) Coordination of efforts of a variety of agencies and professions.

7) Recognition that multiple forces cause and prevent psychiatric disorders.

8) Balanced programs of prevention, identification, diagnosis, treatment and rehabilitation.

9) Sharing of costs of mental health.

10) Provision for program evaluation.

11) Mental health services limited by the limitations of current professional knowledge, and the availability of funds and personnel.

12) Coordinated planning of mental health programs by medical and nonmedical, governmental and nongovernmental local leaders.

The full implementation of this Act was provided by the Lanterman-Petris-Short Act. The latter was an instrument of coordinated planning for utilization of all available agencies, professional personnel and public funds to accomplish program objectives. It established such practical arrangements as a uniform ratio of local and state government responsibilities for financing mental health funds according to community needs. This ratio changed from 50-50, to 75-25 and, as of July 1, 1969, to 90-10; the state reimburses the county program for 90% of its costs. Before October 1, of each year the board of supervisors of each county with over 100,000 population must adopt a plan for mental health services. The plan is the basis for reimbursement. Its purpose is to avoid duplication, fragmentation of services, unnecessary expenditures and to assure that a county uses all existing public and private agencies and personnel.

The California Department of Mental Hygiene administers the Short-Doyle Act. It establishes standards for approval of local mental health services, standards of education and experience for professionals; and standards for organization of services, including maintenance of records, of services, finances, and expenditures. Under such standards, for example, no person, association, or corporation can establish or keep a business for the care, custody, or treatment of the mentally disordered without first having obtained a license from the Department.

The Short-Doyle Act along with psycho-pharmacology has been credited with speeding the return of mentally ill hospital patients to their communities. Since 1962 there has been a steady decline in the inpatient population of California's state hospitals. For a decade prior to 1962 the population has been consistently between 35,000 and 37,000. By 1968 it was half as large. The inpatient population decline was accompanied by a rise in the admission to the hospitals. The general increase for the state hospitals for the mentally ill was about 28 percent.

The older age groups showed the greatest decline in inpatient population. In the absence of complete follow ups of patients discharged from the hospitals it cannot be determined whether many patients left the back wards of the hospitals for the back rooms of the community. However, the best laid plans can be doomed for dismal failure or mediocrity unless the fervor and dedication which initiated the plans are continued and instilled into the greater number of individuals who must implement them.

California which has had the reputation of an innovator of progressive mental health programs may be faltering in this leadership role. The administrative cut backs in personnel, programs and funds that were authorized in 1967 in the name of economy have had their effect in slowing the forward impetus in mental health, and in some cases of pushing it back. The effects would have been even more drastic were it not for the support available through federal funds.

Other states have taken the initiative and forged well ahead of California in such areas as training programs and new careers for workers in mental health. California has been unable to reorganize and take a step toward realigning its functions in treating its mentally ill.

Typical of the deep conflict between the existing system and the system as others see it, is the attitude toward the psychiatric technician training program proposed by a select inter-disciplinary committee of educators, psychiatrists, psychologists, nurses, social workers, sociologists and psychiatric technicians. It had recommended a two-year college educational program for psychiatric technicians that would prepare them to "function therapeutically with troubled people and their families and associates in the treatment facility, the home and the community." The proposed program of study was built around a core of instruction which directly develops and supports the use of interpersonnel processes as personal resources in the psychiatric technician's work. The academic courses were drawn from the behavioral sciences and included psychology, sociology and human growth and development. Although the recommendation was made in October 1967, there has been no serious evidence that it will be implemented in the near future. The program sees the psychiatric technician in a new role, a role which does not include his present nursing function. This has not been acceptable to the present administrators of mental hygiene programs. In the absence of bold action to restructure the functions, the psychiatric technician is forced to remain in a dead-end position. It is of course inconceivable that such a condition can long exist when manpower is needed for the community programs and the psychiatric technician is willing and able to fill that need. Unfortunately logic is not automatically or inevitably translated into reality.

Fortunately there are now many examples of two-year college mental health training programs that grew out of the recognition of the urgent need for middle level professionals. The Purdue Program described by Dr. John True in this publication of convention-institute presentations had its first class of students in 1966. The program, so boldly advanced at Purdue University, has found itself in many similar programs across the country. By the beginning of this year there were twenty-four colleges that had mental health training programs or were planning to establish one.

The Southern Regional Education Board, Atlanta, Georgia, and similar organizations have played and continue to play a most important role in bringing together the needs of the communities for qualified mental health manpower, and the community college resources to produce training programs and recruit students. It also sought to see established in public and private facilities jobs for the graduates of such training programs. It has not been an easy task.

The image of the state hospital as a "custodian" of mentally ill patients changes slowly and with it the attitude toward the mentally ill and the mentally retarded. The state hospitals found it difficult to assume its new role as a center of therapy rather than of custodialism. Its low salaries and poor public image did not attract the professionals it needed for the new therapy programs, and the more humanistic treatment of the patients. In many cases it could not give the attendant a greater share in the treatment programs because they were not trained for such roles. Gradually the psychiatric attendants, aides and technicians were trained to become therapists and rehabilitators rather than mere custodians of the patients.

The therapeutic community that was established in the hospitals to provide an environment more conducive to the patient's rehabilitation was a step toward community programs that could incorporate the best of the hospital therapeutic programs without institutionalizing the patient. The mental health training programs that were established in the community colleges were based upon these humanistic concepts for treating and rehabilitiating the mentally ill. Their curriculums stressed the social basis of emotional problems and included such courses as sociology, psychology, political science, health science and the humanities. In general the courses were organized to emphasize the development of skills that could be used on the job in hospital or community mental health centers. There was also special emphasis on providing immediate opportunity to apply these skills and knowledge in clinical situations; practicums are usually established in a variety of settings in which the students would be employed after graduation.

These two-year courses are aimed to develop middle level professionals. They are established in response to the recognized problem that, while there are shortages in all areas of mental health manpower, the greatest gap is in the middle range. These are the people with a level of skill between the highly-trained professional and the in-service trained aide or attendant. The guiding philosophy has been to train the individual with general and broad skills which could be applied in a variety of settings where effective psychological functioning is important. The students are to become "generalists" in contrast to specialists who are trained for specific functions. The technician who is required to perform a specialized role would be given in-service training in the specific functions of his specialized role.

Support for programs to develop middle level professionals in mental health come from a source other than community colleges and state departments of mental health: the New Careers Program. This new program was authorized by the Congress in 1966, as an amendment (Scheuer Amendment) to the Economic Opportunity Act of 1964. The program is structured around the development of new jobs, training, employment, and careers in human (public) service at the so-called sub or nonprofessional levels. While particularly aimed at assisting disadvantaged populations to help themselves, the concept is also concerned with meeting needs for trained personnel and improving services in the fields of health, public education, social service, law enforcement and public safety, child care, and community development.

The law authorizes grants to or contracts with state or local agencies or private organizations to develop programs. According to U.S. Department of Labor, Standards and Procedures for Working-Training Experience Programs, under the amended Act, "such programs must (1) assist in developing entry level employment opportunities, (2) provide maximum prospects for advancement and continued employment without federal assistance, and (3) be combined with necessary educational training, counseling, and transportation assistance, and such other supportive services as may be needed. A major objective of this program is to contribute to and facilitate the process of designing and creating New Career jobs in public service (either in the civil services or in the private non-profit agencies) as support of sub-professional personnel . . . Such jobs must offer possibilities for continuing full-time employment and realizable opportunity for promotion and advancement through a structured channel of promotion."

Doctor Jacob R. Fishman was co-author of The Community Apprentice Program developed by The Center for Youth and Community Studies, Howard University, Washington, D.C. The program is described in "Training for New Carrers" and published by The President's Committee on Juvenile Delinquency and Youth Crime, June, 1965. In speaking of New Careers in Mental Health, the authors describe the problems:

"In the field of mental health, there has been heavy support by professionals in fostering the use of non-professional workers; yet the professional tends to trust these personnel to perform only low-level tasks. In this context they are "safe" and not at all competitive.

"However, experiences in the use of psychiatric aides at some institutions suggest a number of problems:
(a) The Aides come from varied backgrounds.
(b) Few want to make a career of being a psychiatric aide.
(c) They frequently leave without notice after short employment and move on to other types of work.
(d) A large proportion come from minority groups who have suffered from feelings of insecurity and inadequacy, powerlessness, distrust, and repressed hostility, feelings which are reinforced rather than alleviated in traditional institutional settings. They may see these jobs as undesirable alternatives because others are closed to them
(e) They do not see any future or opportunity for advancement in this work.

"Such experiences have suggested that the most meaningful learning for this group comes from experimental training, concrete demonstration, and active participation with professionals. The degree to which the psychiatric aide can function most successfully alongside the psychiatric nurse depends on the quality and quantity of the conference and training exercises, the personality and motivation of the aide, the skill, creativity, and investment of the teacher, the democratization of the institutional community, and the flexibility and support of the institutional administration. Beyond this, however, the position must carry recognition, status, and responsibility, and have built-in opportunities for advancement and career lines through additional training and responsibility."

They see two primary roles for the nonprofessionals in mental health: healing and service. "New workers will be needed on many levels. Such positions, suggested or under study, include work in case finding, data collection, family counseling, day and night treatment, rehabilitation and occupational therapy, vocational counseling, recreational therapy, group counseling and activity treatment for children, youth, adults and geriatric patients, research, mental health education, and a variety of others."

Doctor Fishman has emphasized that if the New Careers program is to succeed, the entry level job must be a *new* job. When the new job is established it must include provisions for training and credentialing and a clear-cut job description. If these functions are not included during the early phases of planning "it will be extremely difficult to develop a flexible system later that includes career lines."

The career ladder that includes the mental health technicians must also include the mental health aide if real careers are to be established which, by attracting and retaining many highly motivated and qualified people, will help alleviate the mental health manpower shortage. The creation of such comprehensive career ladders cannot be accomplished piece-meal. To fit nicely into a living structure, it means reorganization of the agency or profession. Reorganizations are continuous processes to meet changing situations or to improve functions. Resistance to any change is taken as much for granted as a natural law. Necessity, evidently is not equally compelling to everyone.

The forces set in motion by the unsatisfied needs of our mentally ill cannot be denied for long. The imagination and dedication behind pioneering community mental health legistlation, new concepts for treating and rehabilitating the mentally ill and the emotionally disturbed, new training programs for new classes of mental health employees and the new workers of the New Careers program, provide a formidable armada in the struggle against our society's major casualties.

Zoltan Fuzessery
Director, Research
and Publications

THE PSYCHIATRIC TECHNICIAN SPECIALIST

By Dr. James V. Lowry

Dr. Lowry, Director of the California State Department of Mental Hygiene was unable to present the following statement in person to the delegates and guests of the joint NAPT-CSPT convention institute in San Francisco.

Dr. Lowry received his medical degree from the University of Wisconsin and his training in psychiatry at the U.S. Public Health Service Hospitals at Fort Worth, Texas and Lexington, Kentucky; the Colorado Psychopathic Hospital and the Washington Psychoanalytic Institute.

His assignments include research at the National Institute of Health; Chief of Psychiatric Service, Clinical Director, and Medical Officer in Charge at the psychiatric hospitals of the Public Health Service; Chief of the Community Services Program of the National Institute of Mental Health; Assistant Surgeon General and Chief of the Bureau of Medical Services.

Following his retirement from the U.S. Public Health Service in April 1964, Dr. Lowry was appointed to his present position as Director of the California State Department of Mental Hygiene.

The hospital worker class to which Dr. Lowry refers in his statement was established in 1968 in the California State mental hospitals. The intent in introducing this new class was to release more psychiatric technician and registered nurse time for treatment. The hospital workers performs routine, non-treatment tasks that, according to a survey, constituted 20 per cent of the psychiatric technician's duty time. It is hoped that the psychiatric technician will be able to devote more of this time to innovative treatment and rehabilitation procedures to speed the return of the mentally ill patients to their home communities.

I am aware of some apprehension on the part of the psychiatric technicians that I would like to allay. I do so as an administrator who has crossed a similar bridge in the past and found that it didn't fall down behind me, but instead remained intact and even stronger in its capability to serve. Had I known last winter that you would have extended a gracious invitation to join you at your seminar-convention, I would have kept the calendar open; as it is, I have been committed for almost a year and I cannot be present to respond to any questions you may pose. I hope these remarks are sufficiently manifest so that there are no doubts in your minds about your future with the Department of Mental Hygiene.

Time Magazine, recently, publicly extended to all of you an accolade which those of us in mental health have long and often accorded: you are professionals. In California you are recognized as such. Some of you have reservations about how professional you really are when it comes time to mop the floor, do the dusting, and haul the garbage. Others in the hospitals have also experienced the same reservations. The time is at hand when the psychiatric technician should not be expected to do such chores as a matter of course or routine. Indeed, the time has come when the psychiatric technician and his colleagues in the care and treatment of the mentally disordered and retarded should review their duties and responsibilities.

That last remark has a lot of implications. It means that there are some things being done by physicians and psychologists and nurses and social workers that could be done as well by someone else.

There is more than sufficient capability among your ranks to establish a position of psychiatric technician specialist. What is a psychiatric technician specialist? He is one who is sufficiently advanced in his experience and his education, either from on-the-job education, or through formal schooling received while employed with the Department or before employment, to be able to assist in psychology, social work, or as an assistant to a physician.

This firm conviction on my part is one reason why the hospital worker class has been established. There is no reason for apprehension on your part about the duties the hospital worker may take away from psychiatric technicians. Those duties are not the duties that should be within your routine. You should be freed from those routine chores to assume more responsible duties, as well as continue to perform those duties you do now which are properly assigned.

You aren't going to lose your jobs because of this advancement. That argument was presented to me many times when I was with the U.S. Public Health Service. Once it came from physicians. They felt it was not proper that former hospital corpsmen or others with suitable experience returning from World War II should be trained as quarantine inspectors and determine if a chest X-ray was not normal. Well, no one wanted the inspector to interpret the X-rays; that's the proper function of a radiologist. But the corpsman could — and now does, for example — determine if there is a shadow on the chest X-ray, and then refers it to a physician.

Another example was the resistance of the public health nurses on the Indian reservations. They fretted and protested because of the proposal that some of the intelligent Indian practical nurses could become public health nurse assistants, doing many of the duties that a public health nurse had been doing, thus freeing the latter for more responsible duties. After appropriate training the Indian girls proved they could do the tasks — the nurses didn't lose their jobs. They were needed to provide supervision, and the additional time enabled them to give more attention to the more complicated services.

The same will hold true here. There are some of you who will remain as psychiatric technicians and you will provide guidance to the hospital workers while continuing to provide to the patients the care and treatment programs which are properly yours. Others among you will advance to the psychiatric technician specialist class to do some of the things done by nurses or social workers or psychologists or physicians. A study of the functions of all patient care classes in our hospitals will be started within the foreseeable future. That we started with the psychiatric technician class and are removing some non-technical duties from your impressive list of responsibilities is an action you should welcome. Many of you will benefit. The patients whom we all serve surely will benefit.

There will be more psychiatric technicians needed in the years ahead. The new Short-Doyle Act requires that the private and public hospitals operating under Short-Doyle employ only licensed professional technicians. The state hospitals will need an increased number of technicians to bring the hospitals to the state staffing standards established in February.

I extend my personal appreciation and commendation.

I hope these few thoughts assure you that your futures are bright, not bleak.

THE EFFECTS OF CUTBACKS ON MENTAL HEALTH PROGRAMS

by State Senator Alan Short (California)

State Senator Alan Short, whose 6th Senatorial District embraces San Joaquin County and a major portion of Sacramento County, has served with distinction in the upper house of the Legislature since he was first elected in 1954.

Senator Short gained nationwide recognition in 1957 when he authored and obtained passage of the unique California Community Mental Health Services Act (better known as the Short-Doyle Act). The Short-Doyle Act pioneered a novel method of local treatment for the mentally ill which has resulted in substantially reducing the time needed to return many patients to useful and normal living.

His interest in mental illness and mental retardation stems from service as chairman of a State Senate Interim Committee on Mental Illness in the mid 1950's. Since that time, he has fought vigorously and effectively for improved care, treatment and understanding of the mentally afflicted.

Senator Short was born in San Francisco and has been a resident of Stockton since 1929. He attended the College of the Pacific and obtained his law degree from the University of California's Hastings College of Law.

On the day immediately preceding his presentation at the NAPT-CSPT Convention Institute in San Francisco, Senator Short held an interim hearing on the effects of the financial and personnel cutbacks on California mental hospitals. The witnesses appearing before the Short committee included hospital superintendents, psychiatrists, spokesmen for professional groups, psychiatric technicians, nurses, doctors and parents of retarded or mentally ill children.

The committee on staffing to which Senator Short refers is the California Commission on Staffing Standards which was established by the California State Department of Mental Hygiene in response to a May 1965 resolution of the State Senate. This resolution directed the

Department to evaluate the staffing needs of the State hospitals for the mentally ill and mentally retarded and to report their findings, conclusions and recommendations no later than the 30th calendar day of the 1967 regular session. By strange coincidence the report, recommending personnel augmentations to correct the grave understaffing of the hospitals, was presented shortly before the new Governor announced his over-the-board cutbacks in state operations.

Yesterday we had hearings that attempted to point out as graphically as possible to the people of the State of California, that the state program for people that are mentally retarded and mentally ill is not a good program. It's important that we go on with the hearing as we did yesterday, because it's budget time in Sacramento.

I don't know if there is anybody here from Ohio but I'll just tell you that this administration when it first came into office was a great admirer of Ohio and Governor Rhodes, "old 10 percenter" Governor Rhodes. He was very proud of the fact that when he became governor he cut the budget 10 percent, and that he cut 5,000 state employees from the state rolls.

Now, of course, after his first four-year term he is trying to make up for his past savagery.

It was pointed out in a series of articles in the Sacramento Bee that what happened there was really a decimation of services for the people who are mentally ill.

I give you this background because I want to tell you what the philosophy of our own state government has been. I have to tell you the facts as I see these facts — and I think they're important.

Last year we took to the new Governor a report on staffing standards. We inherited a new administration that said they were going to tighten up — and the words that they used were, "this profligate budget of the State of California." They were going to cut, trim and squeeze. Who did they follow? — Governor Rhodes of Ohio. They used the old 10 percent formula and the various departments, including the Department of Mental Hygiene, were told to submit formulas on how to cut their budget from the preceding year by 10 percent. The Department submitted not one but four plans.

I firmly believe that they never felt that the new administration that took office in January 1967, would ever seize upon one of these plans and start the actual cutting. But as a matter of fact they did.

This was particularly hurtful, as far as I was concerned, because we had at long last gained the cooperation of the California Medical Association to become concerned about what was happening in out state hospitals. They had just finished a year and a half study on staffing in our state staffing. It was a very exhaustive report.

Their action, however, was preceded by a good deal of prodding. There were several Senate Resolutions that were introduced, particularly one in 1965. But I will say this that once they started, they did a whale of a job. They contracted with Aerojet-General for the best minds in industrial engineering. They came in and tried to computerize as much as possible their study. They did time studies of the various tasks that you have in the hospital. In February of last year we had the results of their study and I took them to the new Governor. I don't think he knew what I was talking about, but I did think that I got a point over. Read page 5 of the first volume and you'll see what I'm talking about. That report very definitely showed that we were terribly understaffed, just as we were going into 1967. Yet on top of that the Department went ahead and cut 10 percent.

We held a public hearing in March of last year to try to stop some of this savageness; I think it did some good. Yesterday we finished it off.

Let's see what's happened in the interim. Let's find out what those administrative people in the Department of Mental Hygiene have done in this year's period.

They play a numbers game. They point out that you should cut, cut, cut on staffing because the hospital population, the resident hospital population, has declined. There is no question about that. But how has it declined? That's the important question.

It's declined because you still have a backlog of dedicated people that really want to do a job, that are treating people in the state hospitals better than they have ever been treated before. It's as simple as that.

They forget to tell the public that the admission rate has gone up in the state hospitals. They forget to tell them that those patients that work — and some of them work eight hours a day — many of them are gone from the hospital now. They forget to tell that when you get 70 square feet per patient, it means more work for you. In addition to this you have a more difficult type of patient.

In 1957 I asked the then superintendent at Napa State Hospital to do a pilot study on a group of custodial patients, the back ward patients, those that were incontinent, those that were sitting in corners not moving, only vegetating. They took a part of Napa State Hospital and they provided plenty of staffing. The facilities were crude, but they did give them plenty of staff, — social workers, psych techs, psychiatrists, M.D.'s — right on down the line. I think there was even a nurse.

They worked with a group of 80 women. I think their average stay in the state hospital had been in excess of 15 years; it was a hardcore group. They had been using electric shock on many of them as part of a schedule.

They tried to make human beings of them. They worked with them constantly, teaching them how to take care of their bodily functions, how to communicate with one another, how to sew again, how to take care of themselves.

The results were absolutely fantastic. An amazing number were discharged from the state hospital, because someone cared, because they had a devoted team that worked with them Almost all of them regained ground privileges. Electric shock treatments were almost totally stopped.

The aim of the project was to prove to the superintendent and his own hospital staff that it could be done. They liked what they did and I think it set a pattern that enthused the state hospital staffs to get to the hardcore group and to work with them — to try to do a real job.

I'm convinced that at the end of 1965 we were getting to a point in the state hospital system where we could actually turn to the mentally ill custodial patients and do the same thing for them that was done in the pilot program at Napa State Hospital.

But the cuts absolutely stopped that.

You are the direct shock troop that's closer to the patient than anyone else in the state hospital. You're the most important treating factor. I understand, of course, that these words may be picked up and the California Nurses' Association may call me to task on this, but I think even they'll agree to this — you have the most direct contact with the patient.

We tried a number of years back to encourage the Department of Mental Hygiene to inaugurate a training program for you. They didn't even have any thoughts of having a training program for you. And I remember well the day that we had the hearing on this because two days before they called me and said that they hadn't been able to develop this training program. I said, "You've had plenty of notice. We're going on with the hearing. I'll subpoena witnesses and you tell us you have no training program." So at that time they threw a relatively young superintendent by the name of Danny Laverman into the breech. He was superintendent at Mendocino State Hospital and he outlined a training program. I think many of you subsequently have been through that training program in our state hospital system.

One of the first things they did last year was stop that training program. They fired the shock troops that treat the patients most directly and in the greatest numbers. This is a very sad thing because we let go the newer members who were a devoted, dedicated and well trained group. Since they didn't have job seniority they were let go first.

As was pointed out yesterday, some of the older employees are having a tough time now because in moving patients they need younger blood to assist them on these heavy chores; the incidence of injuries is climbing. But I think the most important effect of the cutbacks was the terrible blow to the morale of the employees in the state hospital system. Morale is tremendously important in the care and treatment of people that are mentally ill or mentally retarded.

Yesterday at the hearing, and I don't know how many of you were able to attend, we had witnesses that testified that only because of the devotion of the employees of the hospital system were we able to continue with any kind of a program in our hospitals. Some of them were working 12-hour shifts.

Now it's my understanding that the Department of Mental Hygiene has concocted a new class of hospital employee because you're getting more professional all the time. I mean, you know you're becoming almost respectable. You were certified; now you're going to be licensed, you know. The whole idea was to upgrade your profession and to put you on a professional basis, to give you dignity and to pay you accordingly. That's exactly what we had in mind. That's what your legislative advocates had in mind. We want you to be proud of what you're doing because what you're doing is tremendously essential in the treatment of the mentally ill and mentally retarded. Without you, we have no program. But because they cut from the maintenance staff, such people as plumbers, electricians, yardmen, someone to sweep the floor, they are now going to come up with a hospital worker class. A hospital worker is supposed to be able to do all of these functions and maybe some of your functions, too. I don't know. I understand there's going to be a hearing before the State Personnel Board and I'm sure the various associations are represented there to give their side of the story. This is another step that they're taking.

For those of you out-of-state, I repeat, they justified the cuts by saying there's been a lessening of numbers in the state hospitals. Once again, superintendent after superintendent says we need more than we ever needed before because we have more admissions than we ever had before. We are treating not only more people than we ever had before, but a more difficult type of patient. To add to our problem, we have lost that cadre of workers that we used to have in the state hospital.

One of the things that was pointed out in the staffing report was that mopping floors, making beds, working in laundries and watching TV is not good therapy for patients. They recommended more personal contact by psychiatric technicians, by psychologists and other members of the therapeutic team. Person-to-person contact programs require generous staffing but it pays off.

One of the reasons that the hospital population has declined – and I say this to you because there is going to be a new look in mental health in California – are the local clinics. We have some 41 clinics in operation and they're seeing over 100,000 patients a year. This I think, is one of the reasons for a decline in the resident hospital population.

But what happens when they certify someone to the state hospital? That person is more severely mentally ill than the type that you used to get previously and needs more work. But the administration does not take this into consideration. They're still playing computer games. This isn't anything I didn't say to them yesterday. I tried to be as nice as possible because I want to be friendly with them and I hope that they'll help to alleviate this situation.

We lost dedicated personnel in California. I put in a series of bills to try to relocate them in other jobs, to try to give them some services. But none of the bills got beyond the Governmental Efficiency Committee. All your salary raises go before that committee, and you know that's important. But we couldn't get the bills out because they cost money and we knew we didn't have a chance to move them along. Even if they had been passed they would have been vetoed – it's as simple as that. The Legislature didn't go along with the cuts suggested by the administration. They added millions in the Assembly to the budget; they added millions in the Senate to the budget. They put a decent program on the Governor's desk – but he deleted millions from the budget destined for the Department of Mental Hygiene and the hospitals.

I understand and I can forgive a new administration because it has a new, a strange and a very difficult job. I'm appreciative of the fact that there seems to have been a turn-around philosophy by the administration. The Governor has stated that they are going to accept the staffing standard report that I mentioned to you. However, the director says that it will be over a period of years in escalated numbers like 250 more this year, 250 the next year and so forth. What he fails to realize, is that pursuant to a furor we had earlier this year in California, when a doctor from one of the Scandinavian countries visited the Sonoma State Hospital and said that the patients were treated like caged animals rather than human beings and that he had never seen a civilized country that treated mentally retarded like we do, there was another report by the California Medical Association; that's what we went into yesterday. The superintendent at Agnew State Hospital stated definitely that the CMA report is absolutely correct in stating that they are 40 percent short of nurses and 50 percent short of psychiatric technicians.

This is the pattern all the way through our state hospitals. We're desperately short now. We don't need an increase of 250, we need far more than that and we need it immediately if we are to continue to do a decent, humane job in our hospitals. It's as simple as that.

I try time and time again to point out that this is not a partisan issue. We do admit that this isn't a problem that arose in the last two years. It has existed for almost the entire time that we've had state hospitals. But it's time to tell this to people in their community and get community-wide support. We want a change, we don't want vast wards crowded with cribs. We don't want mentally retarded crawling around on asphalt hardtop with a wall around them. We want something better than that. We want better treatment. We want smaller and better units. We want enough personnel to really treat these people. That's what we want and that's what we're going to get regardless of temporary setbacks. There are important changes too in recent legislation that will place more emphasis on community treatment; they put a new image on how we treat people.

There is one thing we must do immediately and decisively. Your association can help in this matter. We must demand that the training programs be reinstituted in the state hospitals. Trained psychiatric technicians will be needed all over the state. You aren't going to have any difficulty getting a job. There are convalescent homes, family care centers and other facilities begging for psychiatric technicians.

I was in Los Angeles recently and was told that qualified technicians could almost name their price as far as wage is concerned. There's no question in my mind that you will be able to get jobs. We must therefore inaugurate these training programs because they are the incubator of the talent that is needed for these local programs.

Furthermore, we're never going to give up the state hospitals because we need them; they're the backup program for the local program.

If I were director, I would do several things. I would get out of Sacramento frequently. I would pay unannounced visits to the various state hospitals and not just in the morning or after lunch but at almost any time within a 24-hour period. I think it would be refreshing for you to see the director come walking through the ward and introduce himself and ask you how things are going. He should see what's going on and ask you what your problems are. It would be good for your morale because then you would know that somebody cares how you are doing in your treatment of these patients.

The next thing I would do is to come up immediately and forcefully with a plan that would assure you that you're going to keep your job and be well paid for the work you do. Now that's good for morale too. If you're a younger person and you feel you're going to lose your job, what kind of a job are you going to do on the job? Ask yourselves that. Do you care? Do you get dispirited and start looking around thinking about other things, other places, other employment? Well the answer, logically and sensibly is, of course you do — and it's not good for the patients.

With the advent of medi-care payments, with the advent I think of some social security payments in the field of mental health, there's going to be a vast encouragement for private facilities to enter the field. Several years ago I represented a hospital in Sacramento County, it's a very, very beautiful hospital, one of the most modern in the country, and I asked them, "Why don't you put in a psychiatric wing? We're trying to encourage hospitals, and have for years, to get all the patients together that you possibly can in a general hospital setting." Well they have one now. They have 50 beds in a psychiatric wing in this general hospital and it's working just amazingly well and it can in other general hospitals. It is obvious that there are more private general hospitals than there are state hospitals. Is there going to be room for you? The answer is yes. We need more not less. When we went into the community health facilities I appeared time and time again before the finance committee (before I became a member of the committee) to ask them not to curtail funds for the state-owned, state-run, state-financed out-patient clinics. These clinics, to use the word again, were the incubators of the talent that would go into other communities and other facilities. The same thing obtains as far as the state hospitals are concerned. We must have the training program. It must be an on-going one and you must be assured that it isn't going to be cut off overnight.

If we heard anything yesterday that was gratifying it was this: That in face of the cuts, in face of the heavier work loads, you people have responded in a way that is magnificent. The superintendents show a great deal of pride in talking about the people, the medical personnel, the medical treatment team and what they've done under tremendously adverse conditions. They respect you for it, I know the patients do, and the public should also.

We in the Legislature should do something about it. It's a mean, vicious situation and it shouldn't continue. We can expose it, we can have hearings, we can ask the press to come in. We can try to inform the public as to what's going on. This we can and should do. Don't forget you represent thousands of people. You represent votes – your own vote, your family's vote, your friend's vote. Get hold of your legislator. Tell him the facts of life and don't let this happen.

THE JOB ROLE OF THE MENTAL HEALTH TECHNICIAN

by Harold L. Mc Pheeters, M. D.

Dr. Harold Mc Pheeters is Associate Director for Mental Health Training and Research, Southern Regional Education Board, Atlanta, Georgia. He has held his present position since 1965. Prior to that, he was Deputy Commissioner (Program Administration) in the New York Department of Mental Hygiene. For nine years prior to his New York assignment he was Assistant Commissioner and then Commissioner of the Kentucky Department of Mental Health. Prior to these state positions, he served as assistant psychiatrist at the U. S. Naval Training Center in San Diego and at Ellis Hospital, Schenectady, New York and as Chief of Neuropsychiatry at the U. S. Naval Hospital in Annapolis.

In 1964 the interests of the National Institute of Mental Health (NIMH) and the Southern Regional Education Board (SREB) to increase the manpower supply in mental health agencies were joined around a proposal to explore the role of the community college in mental health training. They proceeded from the well-known fact that professional manpower was insufficient to meet the demands for services in mental health agencies. They saw the need for middle level mental health workers and looked to the untapped resources of the community college as an additional resource for manpower.

NIMH made a one-year grant to SREB to study the role of the community college in mental health training. The principal emphasis of the project was a conference to bring together representatives from the community colleges and the mental health agencies. The conference participants included three men whose presentations at our NAPT-CSPT Convention-Institute in San Francisco in October, 1968, appears in this booklet: Dr. Robert Vidaver, Dr. John E. True, and Dr. Harold L. Mc Pheeters.

I am greatly pleased to be here with your association. For several years now I have been occasionally seeing some of your organization's literature and reports and following your progress from afar. More recently the work of my organization, the Southern Regional

Education Board, in developing a mental health technician program has brought our interests more closely together. I am honored that you have asked me to tell you something of our plans and activities. I am also hoping to meet several of you in person and to learn more about your programs and problems.

Our project in the South grows from the mental health manpower shortage which is especially serious in the South. Until recently the South lagged badly in training programs for professional mental health manpower. Even now, the region, like all of the nation, is lagging behind its needs which are ever expanding with the growth of the region and the development of new community mental health centers, more psychiatric services in general hospitals and new uses of mental health manpower in schools, colleges, courts, prisons, probation, and parole agencies and a host of other programs. It is surely apparent today (as Dr. George Albee made clear in *Mental Health Manpower Trends* in 1959), that there is no conceivable way we can fill our manpower needs with traditional professionals doing traditional things.

At the time of his 1959 manpower study, Dr. Albee suggested that we develop new kinds of manpower whose training would be specific to work in mental health, rather than generic to other fields such as medicine, nursing, or social work. He suggested such a person would require a much shorter training period.

In the past ten years or so there has been a fabulous growth in the two-year community colleges of the South as the states have moved strongly to make a good college education available and accessible to every person who wants it. Miami-Dade Junior College which enrolled 23,000 students last year on its two campuses is an example of this growth. Jefferson State Junior College in Birmingham enrolled over 3,000 students in its second year of classes. These colleges offer four kinds of programs: (1) liberal arts transfer programs, the equivalent of the first two years of any college; (2) the Associate of Arts terminal programs (the Associate Degree in Nursing is an example); (3) certificate programs which range in length from a few weeks to several months, but which do not give a degree. They are usually for highly technical programs; (4) continuing education programs in both technical specialties and in general self-development. These are open to anyone.

In the South there has been a particularly strong effort to develop health-related training programs – especially at the Associate of Arts level in the community colleges. The junior colleges of Florida offer more than 20 separate health-related training programs. It was only natural that mental health technology would be considered.

In April 1966, the Southern Regional Education Board held a conference in Atlanta to bring together educators from the community colleges and mental health professionals to explore whether it was feasible and desirable to train mental health workers in the two-year community colleges. The decision was a resounding, "Yes," and so several colleges undertook to plan training programs for mental health technicians.

These early planning efforts were usually local ventures between a single college and a single mental health agency. Their notions of what they were training varied from a worker somewhat like a psychiatric aide, to a community service technician who would almost never see the inside of a psychiatric ward.

From our vantage point, looking over the 15 Southern states, it seemed that the whole movement would be considerably helped if there were some regional coordination of planning and development. So we have obtained a grant from the National Institute of Mental Health to several aspects of the movement.

The first step is to develop a comprehensive notion of what these people will do in a wide variety of agencies. We expect them to work in many different kinds of positions and settings. Some will surely work with patients in the in-patient services of hospitals and mental health centers. Others will work in clinics and day programs helping with psychological, social and vocational rehabilitation. Others will work with community programs in consultation, education, and prevention. Some will do case findings and referral. Some will work with schools or courts or industry.

We plan to undertake a systematic effort to identify the widest range of mental health needs of people and communities. From those needs we plan to identify specific activities and tasks. We then hope to devise ways of grouping these tasks into jobs that might be assigned to our associate of arts level mental health technicians, as well as the appropriate tasks for other levels of workers. Our present feeling is that many full-professionals are not now being properly used. Rather they are following traditional practices learned in their training days and reinforced by traditional job descriptions.

We believe that while some of these workers may function essentially as aides to social workers, or psychologists or other professionals, it is not our plan to be training aides who will work only under close supervision of a professional. Instead, we envision people who can function with considerable independence of judgement and action though always under the *general* supervision of some professional. We do not see these persons ever working in independent private practice.

Since the basic training of most of these people will be that of a generalist in mental health, it is apparent that a certain amount of in-service orientation and education by his employer will be required for the new worker. Although he will require more supervision in his first months of employment, this should lessen with time.

After this first step of drawing up a guide which may be used both for writing up appropriate job descriptions and for developing curricula for college training programs, we plan to follow both of these courses. We plan on one hand to work with agency personnel officers, mental health program directors, state merit systems, and others in developing actual job descriptions, salary schedules, career ladders, and patterns of administration and supervision. (I suspect this is an area in which you folks can give us some guide lines, for I understand this is where you have had considerable experience.)

At the same time we plan to work with professional associations and clinical program professionals to help them understand the roles of these workers, and how to best supervise them and help them succeed. Without this kind of help we suspect the professionals will feel threatened lest someone take over their jobs. We believe that we can help the full-professionals see their jobs more in terms of planning, teaching, supervising, consulting, and evaluating so that they will not feel threatened when these middle level workers assume some of the direct patient work which they, although gravely overworked, have been trying to do themselves. In this connection we have already been meeting with professional associations and groups within the region to share with them some of our notions about middle-level manpower for mental health.

You have asked about some specific ways in which these mental health technicians will work in community settings. We have not finally answered this, but we have explored ways in which they might be used. Among them are:

A. Work with individual patients or disturbed persons and their families.

   1) Does individual counseling and referral

   2) Does group counseling

   3) Makes pre- and post-hospital care visits

   4) Takes suicide calls and referrals

   5) Interprets laws and policies and practices to families

   6) Makes home visits during and after hospitalization

   7) Leads expatient groups, expatient clubs

   8) Does psychological screening tests

   9) Does emergency consultations

   10) Works with disturbed people in nursing homes.

   11) Assists disturbed people in obtaining transportation, medication, and housing

   12) Works with Alcoholic Anonymous groups

13) Works with emotionally disturbed jail prisoners

14) Assists patients with legal restorations

15) Works in various capacities in day and night hospitals

B. Work with other agencies to facilitate the management of individual cases.

   1) Makes investigations for judges

   2) Assists health department with admissions, releases, and follow-up

   3) Does investigations for hospital staff

   4) Serves as liaison between ministers, welfare officers, employers, vocational counselors, and their returning patients

   5) Works with school staffs – teachers, principals, guidance counselors regarding problem children

   6) Serves as liaison between clinic or center and outlying counties, and agencies

   7) Assists in referrals to occupation centers and employment in general

   8) Initiates proceedings for incompetency hearings when indicated

   9) Does investigations to determine residence and follow-up studies for other states

   10) Does home investigations, studies, and referrals for juvenile court

   11) Checks on broken appointments

12) Attends staff conferences of other agencies on behalf of patients

13) Accompanies police or sheriff on calls regarding disturbed people

14) Does screening psychometric studies for schools, vocational rehabilitation, crippled children's agencies, etc.

C. Consultation to other agencies regarding mental health problems in general.

1) To juvenile courts, police and sheriffs

2) To schools – principals, teachers, counselors

3) To health departments

4) To mental health planning groups – including mental health associations

5) To vocational rehabilitation agencies and sheltered workshops

6) To welfare and child welfare agencies

7) To associations for retarded children

8) To other state and local agencies

D. Teaching

1) School students regarding alcohol, sex, mental health

2) Jail personnel

3) General public regarding mental health, mental illness, mental retardation, treatment, and resources.

E. Community Action

1) Serves on board of mental health associations

2) Promotes development of expatient clubs

3) Promotes and mobilizes action for mental health services such as sheltered workshops, halfway houses, or nusing homes

4) Interprets community needs to state agencies

5) Assists in mental health surveys and assessments of need

6) Helps communities organize preventive programs

7) Serves on committees and boards for retarded children, rehabilitation, juvenile delinquency.

8) Serves as a general resource person

F. Administration

1) Keeps data on local problems

2) Prepares reports

3) Provides for administration of emergency services (call roster, etc.)

4) Orders, distributes and reports on medication supplies for patients

5) Maintains contact records and files

G. Research

1) Does studies of special local problems

2) Does analyses and evaluation of his own program

Our other major activity will be to work with the community colleges themselves to help them organize these training programs. This would consist of help in obtaining financing, recruiting faculty, developing curricula, planning field experiences, and recruiting and selecting students. Obviously each college will do the major portion of its own planning with a local advisory committee of representatives of the agencies that expect to employ the graduates. To be sure that they haven't overlooked some major aspect of such planning, both local committees and college planners have contacted us for planning guide lines and consultation.

In addition to the April, 1966 conference in Atlanta, we have held two further meetings in the past two years with persons from all of the two-year college programs in mental health in the United States. There are currently about 20 such programs – mostly in the South. Nearly all are training a mental health generalist though a very few are specializing in a specific area such as mental retardation, alcoholism or community services technology. Most of the classes so far are small – less than 30. A very large proportion of these first students are women, many of whom have worked as psychiatric aides in mental hospitals. In fact, many of them, especially in Maryland, are receiving stipends from their place of work while they attend these courses. Obviously there are serious problems to be overcome in recruiting more young persons, especially men, right out of high school.

The solution of the recruiting problem will depend on the jobs that will be established for them. If the jobs provide sufficient opportunity, dignity, and especially salary, there should be no problem in recruiting men. At this moment only one program has graduated any students – the Purdue program at Fort Wayne, Indiana. Dr. John True will tell you more about that program.

Although state departments of mental health have made firm commitments to use these people, a great deal of the specifics of salaries and job duties must still be developed by them. This may take at least nine months. Some of those programs are looking forward to the field experiences of these students to better understand just what they can or cannot do.

In general, however, we expect the salaries to be about the same as that of a beginning nurse with an associate degree. In most states there is a strong expectation that these people will have career ladders open to them. In some states (Illinois), there are college and agency programs developing for Bachelor Degree and Master's Degree Mental Health Workers. In other situations these workers will probably go on into one of the established professional fields — nursing, social work, vocational counseling, and psychology. In either case, a strong recommendation for the Associate Degree at the start is that approximately one year of the two academic years of schooling is transferrable to other liberal arts colleges. Thus, the individual has training which will enable him to find early employment in his chosen field while he is also able to go on for higher degrees of professional training.

Our project also proposes to play a major role in evaluation of this whole mental health technician system. We plan to look at how, and how well, they function. What roles do they do best? What are the best training programs? What field experiences are most useful? What are the most useful recruiting devices and who should be selected for these college programs? These are some of the questions we hope to answer over the next few years.

In all of this, the Southern Regional Education Board's role is to expedite and facilitate. In the past, professions and technical specialties have evolved over a period of 25 to 50 years. In 1968 it appears to be about time for us to be able to assess the needs for newer manpower specialties and speed their development in a more rational way than happens when events are allowed to progress at their own rate. It may interest you to know that this is not the only middle-level mental health manpower effort in which SREB is engaged. We are also strongly invested in a project to train and use more baccalaureate level social welfare workers — social workers, vocational counselors, and the like. We have also done some explorations of the possibilities of developing terminal Master's Degrees in Clinical Psychology where the present minimum is the Ph.D. We have also recently been exploring the whole area of the health related professionals and the many technicians and aides in that broad area. We see ourselves as expediters for the most effective training and use of all manpower in these areas and not as an advocate for any particular one. This is the one way in which we differ from your particular organization, but we welcome your interest and suggestions.

THE NEW ERA IN MEDICINE

by Dr. Earle M. Marsh

Earle M. Marsh, M. D., is coordinator, allied health professions at the University of California, San Francisco Medical Center.

Dr. Marsh received his medical degree from the University of California School of Medicine, San Francisco in 1939. His postgraduate training in gynecology and obstetrics was taken at the University of California Medical Center at San Francisco. As part of his tour of duty with the U.S. Naval Reserve he participated in postgraduate training in psychiatry at the Chestnut Lodge Sanitarium, Rockville, Maryland, St. Elizabeth's Hospital, Washington, D.C., and the U. S. Naval Hospital at Bethesda, Maryland. He's a diplomat of the American Board of Gynecology and Obstetrics. In his role as medical educator he is assistant clinical professor of obstetrics and gynecology and coordinator of allied health professions. In his presentation he describes some of his experiences as coordinator. He also has teaching and administrative positions in three San Francisco hospitals: Children's Hospital and Adult Medical Center, Franklin Hospital and San Francisco General Hospital.

In addition to the many articles he has written on clinical medicine and public health, Dr. Marsh has been very active in the development of films and the use of television for health education of both the professional and the lay public. He is vice-president of Professional Arts, Inc., which specializes in producing medical educational films. He was narrator for the television series "Doctors at Work." It comes as no surprise to learn that he is also a member of the Screen Actors Guild.

His interest, wide experience and knowledge in his professional specialties, public health and medical education are reflected in the numerous national, state and county professional societies in which he is an active member. These include the National Council on New Careers and the Association of Schools of Allied Health Professions. Not least of his many activities was that of gynecology consultant to the Institute for Sex Research in the publication of "Sexual Activity in the Human Female."

I would like to discuss a little about what seems to be happening in the entire field of medicine. We've entered a brand new era. The old era of hypodermics, pills, liquid medications, and of the dentist's drill, casts and gadgets is, of course, still here, but it's now secondary. We have entered a brand new era. We have entered the new era of "you" and the era of "me", "us". Who are we and who are you and who are we as a group? How do we function with one another in some sort of coordinated effort to bring healing to those who need our services?

It's no longer possible for one person to be all things to all people. It has been the great dream of the American physician to be all things to all people. He looked to his own being and to his own talents to carry all of the healing paraphernalia to each and every patient in totality. He was essential; no one else was. But we have entered a brand new era where this is no longer true.

We're in the era of "us" and that's why you folks meet. That's why your organization is growing in leaps and bounds because you are needed by the clinical psychologist and the psychiatrist. You are a vital therapeutic link to the patient. You have more contact with the patient than others have. Within your hands rests a very vital tool in offering healing to patients.

Let me drop that for a moment and proceed to a few bits of data. In our western culture we have also entered a new disease era. We are stepping from the era of acute infection to the era of chronic disease. We no longer have acute infections that wipe out vast numbers of people. Smallpox is no longer with us. In essence typhoid fever and poliomylitis are things of the past. We had, for example, twelve cases of poliomylitis in the entire United States last year, compared with previous years when we had hundreds of thousands of cases. Although there have been recent upsurges in venereal disease and tuberculosis, the incidence of these diseases have been markedly reduced. We are in the era of such simple chronic diseases as athlete's foot, varicose veins, and metabolic diseases. We are in the era of high blood pressure, ulcers, cancer and strokes. It is the era of illnesses which in general do not take you and me quickly like an acute disease but come on insidiously, like arthritis, for example.

The medical experts say that each of us carries from the day one to the age of 15 years one half a chronic illness.

It is surprising but true that even youngsters have chronic diseases. From the age of 15 to the age of 40 you and I carry 1.2 incidence of such chronic illnesses as arthritis, diabetes, and obesity. From the age of 40 to the age of 65 this figure reverses itself and we carry 2.1 chronic illnesses. After the age of 65 the load increases to 4 chronic illnesses. It looks rather frightening when you first think of it that the older we get the more crippled we become. Yet, on the other hand, this is simply a way of stating that as we grow older we develop the process of aging.

In the medical scene, in the health scene, we don't hope to convey immortality to the American public. One doesn't feel as a health personnel that the day will come when we will all live forever. As a matter of fact this probably isn't very good. Not too long ago I read a book. A man was granted a wish that he could live forever. At the age of 200 he committed suicide. He just couldn't stand all this nonsense. However, although we do not foresee living forever, we could completely eradicate 50 percent of all of the chronic diseases by our present diagnostic and therapeutic techniques, *if we could just get to the American public.* Getting to the public is the big problem.

One of our big concerns in the health field is about what we call MYA or Man Years of Adaptability. This refers to our capacity to adapt to this constant onslaught of chronic illness. Medical experts say that we can divide people into high and low adaptability. Some people have a high resilience or resistance to chronic illness; they are slowed down, but not too much, by the increasing number of chronic illnesses that are piled on them. Other people are almost completely stopped by a few chronic illnesses. We say that their adaptability is low.

Recent data, collected in some major U. S. cities, reveal that in a given year, only 2 percent of the American public go to a hospital. The same data reveal that in a given year 18 people out of 100 go to see a doctor in his office or go to a clinic. Simple arithmetic reveals that in this world of plenty, 80 percent of the American public receive no medical care whatsoever. Although all of us, including this 80 percent, have this constant onslaught and accumulation of chronic illnesses, half of these chronic illnesses could be eliminated right now if we could just get to the people. It is little wonder that the American medical philosopher, which includes you and me, have become interested in our capacities to adapt to this onslaught of chronic illnesses. We have at the present time more than 200 million people in the United States. The population experts estimate that within 40 years – we will have 400 million people. This means that we will double our population or come close to it. This means that, by the turn of the century, you and I and the next generation will be shouldering the responsibility for 400 million people. Eighty percent of these people will receive no medical care unless we do something about it. All of them will bear this incidence of chronic illness that piles up the older they get, half of which we could completely eradicate right now if we could just get to the people.

There is another little bit of data that is of particular significance to the health field. The number one industry in the United States today is the building trades. It is followed by agriculture as the number 2 industry in the United States. The number 3 industry in the United States is the health industry. The health industry, in terms of employable personnel is at the present time the third major industry in the United States. However, within 18 months health will supplant and exceed these two and will become the number 1 industry in the United States.

Another interesting bit of data reveals that we are not only in the middle of a "population explosion" but also in a "knowledge explosion". Ninety percent of all of the scientists that ever lived are still alive. We have discovered more scientific facts, physical, physiological, and psychological, in the last 30 years than we have in all of the rest of time. We are having a fabulous explosion of ideation. We will discover more scientific data in the next 5 years than we have in the last 500 years. As a matter of fact, we're discovering about 500 scientific facts a day.

Side by side with the increasing output of knowledge there is also a "knowledge hunger". People are anxious to go on to school. You've been listening to this, this morning. Who do we need to train? How shall we provide them with lateral and upward mobility? People are hungry to learn. It's judged that by 1972 that 70 percent of all Americans, irrespective of color, will go on to college. Of that 70 percent, about 30 percent will go to baccalaureate level or above. Seventy percent of those entering college will go on to something less than the baccalaureate level. This by far exceeds the expectations of any other country. We are undoubtedly in the midst then of a knowledge hunger.

Classically we have always had business: a therapeutic scheme in which the doctor was the supreme being. This is understandable. The doctor was the first one on the health scene; in essence he was the first sibling.

But he became so busy that he had to create others. He had been doing his own nursing, taking temperatures, giving enemas, or pulling his patients teeth and compounding his own drugs for them. But the workload forced him to create helpers like nurses, dentists and pharmacists who eventually became professionals too. As knowledge and technology increased, he created specialists like the x-ray technologist, the medical laboratory technologist, the dietitian and many others. In 1910, for every hundred doctors there were 40 people who were helpers. At the present time, for every hundred doctors there are 1400 helpers.

As the doctor created these helpers he maintained himself in a supreme position: he called all of those underneath him "sub-professional." He felt that they weren't as professional as he was. But one day he realized that he was outnumbered by these "subprofessionals" and he started to reconsider. Is this an appropriate way to address his less than human conferees? He came up with the word "paramedical." This sounded innocuous enough, until one day one of the paramedical people looked up the prefix "para" in the medical dictionary and there were two rather acceptable definitions. One was "near to and with", but he also found that "para" also meant "above, and in antagonism to" and this was not good. They tried to get rid of that word but we aren't rid of it yet.

To replace these terms the medical profession slowly has created the words "allied health professions." This implies that you and I are allies.

You and I are together, as allies. We have some need to work together and we look forward to a scheme that will one day have the doctor as the director of a group of people who will be not under or in antagonism to him but next to him. This would include the nurse, the psychiatric technician and all of the technologists. In San Francisco we decided it was about time we did something about our national health manpower problem because we need about a million and a half workers in the next ten years in all fields. This means that we need about 10,000 people a month. We can't possibly produce that many people, and we can't particularly call them paramedical and subprofessional. I'm talking now as a doctor who might feel still at the top the peak of the team. It's awful hard to get dislodged. The first sibling gets jealous of the second sibling. So it is no wonder that the doctor who was the first sibling jealously guards his prestige and fears any loss to it. But doctors are so powerful and have so much prestige that we could afford to give away some of the power; we are so power-heavy that our backs are breaking.

So deciding to do something about our health manpower problem in the San Francisco Bay area, we had meetings with the colleges and hospitals in the area. These included public and private colleges and hospitals. I represent the University of California Medical Center and Children's Hospital in San Francisco. We found that each of the schools was trying to produce health professionals. None of them knew what was going on in the other colleges for training health professionals.

This lack of coordination is not surprising. We all get too busy in our individual professions to see what is happening elsewhere.

We have finally brought all these people together and they were convinced that the health personnel should be trained in some unified, coordinated way. We are setting up in San Francisco what is known as a Health Professions Council. This is a combination of the producers, meaning the educators, and the consumers, meaning the professions such as you represent. We are trying to find answers to such questions as — Who needs to be trained and for what? How many people do we need and where? What kinds of technicians do we need?

It became perfectly apparent that we not only had a great shortage of health personnel but the people that we did have were being inappropriately used. Such misuse of personnel leads to confusion, loss of morale and hostility among hospital groups. The patient is caught in the middle of this muddle and his care and treatment suffer. Everybody hates everybody else and all go home mad. The patients can't get out of the hospital soon enough, and wonders why he went there in the first place.

We decided to do something about it; we wrote a paper entitled "Patient Care and the Manpower Problem." At several of the local hospitals, we called together the hospital administrator, the assistant administrator, the director of nurses, the chief occupational therapist, the chief physical therapist, the chief dietician, the chief x-ray technologist, and all the other key personnel and department heads. We asked, "What can we do to make our atmosphere a little more welcoming to patients so they won't get caught in this bind of ours, in this traffic problem of ours? In other words what can we do to improve patient care?" When they asked what we meant, I told them a few true stories of life in a hospital.

I told them about a professor of surgery who was operated upon in his own hospital. He was a little reluctant to talk about his experiences, particularly since it was his own hospital. But he felt that he had never been treated as rudely as he was at the admitting desk. He was kept waiting so long that the very walls seemed to change color, grow darker and become grimey. When he finally arrived in his hospital room, he did not recognize it although he had seen hundreds of his patients there. He was now on the other end of the thermometer and everything seemed strange, unfamiliar and unfriendly. Only in the black telephone did he recognize an old friend. The room was like a dungeon. The eighteen separate hospital people who came to visit him and take some of his body specimens were matter-of-fact and grim. It didn't help when at surgery the anesthesiologist had trouble hitting the vein. On the fifth post operative day he was rather uncomfortable. He had a long incision and wanted to turn over in bed. When he turned around to ask the grandmotherly private duty nurse to help him he noticed that she had fallen asleep in his easy chair.

When they asked for further clarification on what to do to improve patient care, I told them about the four visitors to a sick relative. They were two rather obese women and two rather slight men, apparently their husbands, who he noticed were tightly hugging the wall near the recovery room. The hospital auxiliary was distressed and asked me what she should do about getting these people to the hospitality room. It was against hospital rules to have them remain in the hall. It seemed that hospitality was dispensed only in hospitality rooms and not in other parts of the hospital. It was also obvious that these visitors had no interest in hospitality rooms; they only wanted to be near their relative. They were satisfied to be absolutely silent as long as they could be as close as possible to their sick kin. When I suggested that she get four chairs and four cups of coffee for them, she cited the hospital rules. It was only after consulting with the hospital administrator and the patient's surgeon that it was possible to bend these rules. I wondered whether we could not have more flexibility in hospital rules and improvement in patient care.

To illustrate further the flexibility that was needed, I told them about the exceedingly well-to-do woman I had operated on recently. She had everything. After her operation she was depressed and not responding to treatment. When I asked her what the trouble was she would not say but asked whether I liked dogs. Then a light dawned and I realized that she did *not* have everything. I asked whether she would like to see her dog. When she said, "oh, yes", I wrote on her chart, "patient may see dog 45 minutes three times a day before meals." This set off a conference with the hospital administrator, when he heard about this. It was against all hospital rules. The dog would contaminate the hospital and so forth. But therapy finally took precedence over hospital rules and she was able to have her visitor. Within 48 hours she was ready to go home.

The group finally said that they understood what we meant. Then we decided that we would visit one another's departments. I said, "Why don't we visit the occupational therapy department. Let's pretend we have never seen occupational therapy." I wasn't sure these people knew where the various departments were. Although they assured us that they knew all about occupational therapy, I told them reindoctrination might reveal something new; the occupational therapist would show us occupational therapy through her eyes and we would try to see it through her eyes. She talked about 15 or 20 minutes and we agreed we would act as outsiders. We got along about 15 minutes and suddenly the physical therapist, whose department was located on a different floor, said that what the occupational therapist was describing was not an occupational therapy job but rather a physical therapy job. The director of nurses said that they were both wrong because it really belongs to nursing. They got to hating one another. The same thing happened in the other departments we visited. We all got to fighting over one another and got to hating one another. Some people said they would never come to another meeting.

But we kept trying and we set up encounter groups. We had groups of hospital personnel meet together for a weekend. We talked things over and learned to encounter one another: Who are you? What are you made of? Yesterday we finished a three-day workshop at St. Francis Hospital. On the second day they were going to skin me alive. Last night they were full of love and understanding for one another. We extended these workshops to medical students, nursing students, occupational therapy students and other students in the field.

What can we do to somehow draw ourselves together into a desperately needed health team effort? What do we do to draw ourselves together? How can we unify our efforts? How can we get to know one another? How can we be drawn together in some degree of intimacy so that we can spontaneously realize that what we need in the hospital is the psychiatrist? You folks are ahead of the organic physician. You have these health teams going. You have psychologists and psychiatric technicians and many others, and though they may at times hate one another, they are somewhere drawn together in some unity. We have to have the temerity to look one another in the eye for longer than just a brief interval until we can look beyond the exterior and see the glimmer of a soul behind that eye. I don't care whether it's another health professional, a patient, or the grocery clerk. Can you look and can you see that behind those eyes is a soul that reaches for you, very timidly and very apprehensively? Can you become aware of the fact that you are also timid and also cruel? Can you reach inside and take the little you which you know so well, but nobody else knows, and offer it to someone and say that it may not be much but it is all you have – it is you? Only by making such an offer can you hope to receive a similar offer. When you in turn receive such an offer you can lay the two inner selves side by side and you may come to realize how similar they are. Then you may come closer to knowing your own identity and the many roles you must play to live a full and meaningful life.

MENTAL HEALTH TRAINING IN JUNIOR COLLEGE

by Walter R. Kersey

Mr. Walter R. Kersey has been closely associated with the psychiatric technician since 1945. He served as a psychiatric attendant and psychiatric technician from 1945 to 1963 at Utah State Hospital in Utah, and Pacific and Patton State Hospitals in California. From training assistant at Patton State Hospital he advanced to his present position as training officer with the California State Department of Mental Hygiene.

Mr. Kersey received his Associate Arts degree from San Bernardino Valley College and his A.B. and M.A. degrees from the University of California at Los Angeles. Prior to his service in the state hospitals in Utah and California, he was an instructor in the Los Angeles secondary schools.

He was a member of the Psychiatric Technician Training Committee, appointed in January 1967, by the Director of the California State Department of Mental Hygiene to "recommend a plan for training psychiatric technicians in California." The report of that committee was presented to the Department of Mental Hygiene in October 1967. Its recommendations for an Associate Arts degree program for psychiatric technicians has to date not been implemented. Mr. Kersey's tour of selected colleges with training programs for mental health workers was made to provide additional data for evaluating the recommended training program.

This June the National Institute of Mental Health provided travel funds for me to visit five colleges across the country that are starting associate-degree programs to prepare students for mental health work. One of these is a four-year college, Metropolitan State College in Denver. The others are junior colleges: Sinclair Community College in Dayton and three colleges in the Baltimore area, the Community College of Baltimore, Catonsville Community College and Essex Community College. All of these had just completed the first year of classes, except Essex, which plans to start its first class this fall.

Later at this convention you will be hearing from Dr. Vidaver, who has had a great deal to do with getting the Maryland programs started. You will also hear Dr. True, whose program at Purdue started two years ago and now has graduates in the field. You are fortunate to have these men here, because the programs they have started, and the others like them, are an unusually important development.

For years we have been talking about junior college degree programs, and about new curricula for mental health workers that stress the behavioral sciences. This year for the first time, both are in existence at all the colleges I have mentioned, and I believe in a number of others too. I expect many more will start soon, partly because the programs I have seen have so many common features. As you would expect in pioneer programs, each reflects the enthusiasm, knowledge, and personal drive of a few dedicated people who are getting the program started. But despite this individual character, a more remarkable feature is their similarity to each other.

They have four basic similarities:

First, they are all two-year programs to train high school graduates to provide services now provided by psychiatric technicians and aides. In every case, it is expected that some of the graduates will work on wards in state hospitals, and others will provide equivalent services to people in other settings. In some cases, treatment institutions near the college expect that all their present staff of psychiatric technicians or psychiatric aides will be retained or replaced so that all ward staff at this level will be college trained. In most cases, the institutions are sending some present psychiatric technicians to college at full pay, while they work half-time on the job.

Second, in every case the college expects that graduates of this new program will also work in places where psychiatric technicians do not now work to a great extent. New job placement settings include general hospitals, correctional services, and neighborhood services.

Third, each program has a substantial component of academic work of essentially university quality, and strongly emphasizes the behavioral and social sciences. There is relatively little physical and biological science, and almost no medical or nursing content. Graduates are in this way differentiated from the graduates of any other training for employment which the college offers. They can generally expect to earn substantial credit applicable toward baccalaureate degrees in fields like sociology or psychology.

Fourth, graduates of the programs will have had substantial practice in settings in which it is expected they will be employed. Though these programs have strong academic components, they are primarily planned to prepare people for employment. The program directors expect that graduates will be employable, in many kinds of places. If they are right, we may expect that the number of such college training programs will increase throughout the country.

It would be easier to respond to the college scene if what I have already said were all there is to report. But the educational riches this year are even greater. Perhaps only one other development needs to be mentioned to illustrate the complexity of the situation. This has also been the year of the psychiatric technician licensing law. Both Colorado and California now have such statutes, and in both cases the licensing of psychiatric technicians includes a prescribed training program. In both cases the course, as now prescribed, centers on nursing knowledge and practice, covering almost all aspects of nursing to some degree. The licensed psychiatric technician may thus be properly perceived as a member of a branch of nursing, as his antecedents in hospitals have been.

The logical next step is already taking place. In California, most junior colleges have either two-year courses for registered nurse training, or one year, or year and one-half courses for licensed vocational nurses. The existing nursing faculty and existing vocational nursing courses can be used to good advantage in the preparation of psychiatric technicians for licensure. With another semester or more, the student can usually get an associate degree also. This development is as logical in California and Colorado as courses based on behavioral or social science. And related developments in states without licensure laws are increasingly making nursing courses available to workers with the mentally ill and mentally retarded.

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What should I do with all these riches? We are apparently entering several educational "promised lands" at once. I think we can rightly rejoice. Either of the events I have mentioned – the new associate degree courses based on the behavioral sciences, or the new licensure laws – may do as much to bring more professional services to patients than any other development of recent years in the mental health field.

Should the professional organizations of psychiatric technicians then merely allow these developments quietly to take their course? I think not. While we rejoice, there is obviously a great deal to do yet. Let me suggest two difficult kinds of questions both individuals and organizations have to consider as a result of what has already happened.

First, is only one kind of basic college training enough to prepare for all the tasks psychiatric technicians do, will it be necessary to prepare some technicians for nursing and others for functions based on the behavioral and social sciences, and still others for housekeeping tasks which do not require college?

I think we may be about ready to agree that some housekeeping tasks are not the basic job of psychiatric technicians, and that, as far as possible, people trained in housekeeping ought to be employed to do that job.

The problem of training for different kinds of patient services is even more difficult. If there is a substantial non-nursing service to be provided by people trained in the social and behavioral sciences, who should do the physical nursing many psychiatric technicians now do? Should these tasks be assigned as far as possible to people fully trained in nursing?

Second, will the new associate-degree graduates in the behavioral sciences oriented programs separate into yet another occupation? The colleges that train them now call them mental heatlh workers or mental health technicians. Furthermore, the new graduates are reluctant to be labeled psychiatric technicians, which, in most places still means an academically untrained and poorly paid employee. In addition, in California and Colorado, where the technician has more prestige, the new graduate must define his practice so as not to run afoul of the psychiatric technician licensing laws.

From this you can see that it becomes more than a question of the kind of training; it may be a question of whether any of the people who acquire associate degrees will want to be identified as psychiatric technicians.

If these questions are sticky, there is a different kind of question which should preoccupy us even longer, in fact forever: How can we prevent college training from disabling us for useful work?

College training is the wave of the present and of the foreseeable future. It is the first criterion of competence in occupations like ours, as I implied in my earlier statement that this year's developments in junior college training for mental health work are a milestone in bringing more professional services to patients. But that statement begs the question, whether more professional services are *necessarily more useful* services. And whether college training gives a person new skills while depriving him of some old skills.

As we are about to embrace a general educational increase for ourselves, we may profitably look at some of our past experiences with professionals who appeared to be handicapped in basic skills like talking to a patient in language he could understand. Are psychiatric technicians about to extend this handicap among themselves by becoming the proud possessors of degrees? When such a thing happens, it is almost always unawares; it is very difficult to believe that you make a great educational effort, are rewarded with praise and more pay, and end up having actually lost some skill in the process. But it can happen here. What you observed when the doctor didn't make sense to patients and probably didn't know what was wrong, is worrying many doctors and other professional people too. It may as well begin to worry you from now on.

Are you going to be so highly trained, for example, that a new "lower" employee class of hospital workers will increasingly have the job of actually talking to patients, staying with patients, treating patients much of the time? Will this also happen to the indigenous mental health aide who without much training can help his unfortunate neighbors in solving daily practical problems in living? Will his usefullness be educated out of him?

This probably doesn't have to happen. The designers of new college courses, who are all including a great deal of practice in the job setting along with the academic work, are trying to avoid educational futility. We will all have to help them. We will have to learn how to enlist the people we serve, patients, and clients, in helping us help them. When we learn better what services patients really can use beneficially, we will probably have to serve notice on the colleges to scrap much of the educational advance that we are hailing this year as a great breakthrough. Today, when we feel very good about the new training that is available, we should look forward to the day when it too will have to be changed or replaced by newer programs.

THE PURDUE PROGRAM FOR MENTAL HEALTH WORKERS

by John E. True, Ph.D.

Dr. John E. True is associate professor of psychology and program co-director in mental health technology at the Fort Wayne Campus of Purdue University.

The Purdue Program for mental health workers, a pilot program, the first of its kind in the country, provides a new entry for those interested in working in the field of mental health. The curriculum is a combination of general education, specialized courses in areas directly related to mental health and supervised experience in mental hospitals, clinics, homes for the retarded and other community mental health settings. The two years of intensive study and work are designed to develop both a basic understanding of the field and desirable attitudes and skills in persons who will work closely with the emotionally disturbed and the retarded. The two-year associate degree program was developed under a five-year National Institute or Mental Health grant obtained in 1965.

Dr. True is a graduate of Purdue University and obtained his Ph.D. in 1962. Before coming into his present position he was staff psychologist at the Veterans Administration Hospital in Cincinnati and an instructor of psychology at the University of Cincinnati.

In his presentation to the delegates and guests of the NAPT-CSPT Convention Institute in San Francisco in 1968, he describes the origins and rationale of the program, its problems and successes. As the "grandfather" of similar two-year educational programs for mental health workers that are developing across the nation, the Purdue Program's development is of particular importance to individuals and agencies who are contemplating developing or have initiated plans for such programs.

INTRODUCTION

I am pleased to have a chance to share with you some of my experiences with a very exciting program which we are developing in

Ft. Wayne, Indiana. It is a program which, with other programs, is setting a pattern for what I think is going to be happening all over the country very shortly.

Others have already described to you the big picture in mental health and most of you are very familiar with it. Therefore I will not talk about the general trends in mental health, including the move towards the community, other than to say that these trends provide the background and context in which our program is developing.

I find it difficult to realize that our program in Ft. Wayne which is only two years old is regarded as the "grandfather" program for the country because it was the first one developed. In two short years we have become a grandfather although we certainly do not feel like a grandfather program. To us it is still very new and we are very much aware of being in an experimental phase. We are not entirely sure of the directions that we will be taking. We have made many changes and expect to make more in the next several years.

We are now in our third year of operation and just started our third class. There are 61 students in this two year Associate Degree program located on a regional campus of Purdue. The Fort Wayne Campus of Purdue University is one of four regional campuses. Currently we are the only campus which has a mental health technology program. However, we are planning to expand this program to at least one more campus by next year. The first class of students graduated last June. A little later I will tell about these graduates, where they went and what they are doing.

HISTORY OF PROJECT

I would like to give a little history of this project. What happened in our case is probably very similar to what is being experienced in developing other programs. There are currently, as Dr. Mc Pheeters indicated in his presentation, between 20 and 25 two-year level programs throughout the country. As you can see we are witnessing a rapid growth in this new vocation. We expect this rapid growth will continue in geometric proportions over the next few years.

Purdue received a grant from the National Institute of Mental Health July 1, 1965, to support the development and evaluation of a two-year program for the training of mental health workers. The proposal resulted from the merging of several streams of thought. Representatives of the Indiana Department of Mental Heatlh expressed concern over the quantity, quality, and turnover in mid-level personnel. At the time of the conception of the program, Mr. Bernard Dolnick, then Superintendent of the Fort Wayne Hospital and Training Center, spearheaded the project with his conviction that the "mid-level" personnel were actually the front-line of mental health programs. He stressed the dead-end nature of the careers in this area and urged the development of a training program for a generalist worker. It was his concept that ultimately this vocation should have several levels of responsibility with corresponding training and experience requirements. The Commissioner of Mental Health of the State of Indiana at that time was Dr. S. T. Ginsberg who expressed his agreement with interests already mentioned. In addition, he endorsed the concept of pre-service training as preparation for a vocation, in contrast with on-the-job training for a job in a particular setting.

A second stream of thought leading to the inception of the Purdue Program came from the Regional Campus Administration of Purdue University. Purdue University has long been engaged in training engineering technicians and has been awarding a diploma for the completion of two years of study since 1943. Recently the Board of Trustees of the University authorized the awarding of the Degree of Associate in Applied Science. This degree is awarded after the completion of a two-year curriculum designed to provide students with job-entry training. The student may, however, elect to continue his studies to the Bachelor's degree level and his work toward the Associate degree will apply. Obviously, then, the student can continue his education to the Master's degree and to the Ph.D. or the M.D.

The general philosophy of the University is that there exists an overwhelming need in many fields for technically trained personnel. Furthermore, the effects of the "population explosion" on institutions of higher education make it mandatory that methods be devised to provide some college education to larger numbers of students than can be accommodated on the main college campuses. The Associate degree program is designed to prepare persons for early entry into the "world of work" or for continuing education. At Purdue, the School of Technology is the agency of the university charged with the development of such programs. This school has recognized that many persons might be more interested in vocations dealing with people than with traditional engineering activities. Consequently, they planned to offer the Associate degree in areas other than engineering technology. To this end, a two-year nursing curriculum had already been initiated. The training of mental health workers was proposed as another area of training.

It was also recognized that there are many potential workers, such as workers displaced by automation or housewives whose children have become self-sufficient, who might take advantage of a two-year job-entry training program but who could not contemplate more extensive training. The training of middle-level professional personnel for work in the mental health field appeared to be an important area both for young people and the latter group.

A third stream of thought which merged with those I have described was the recognition that many persons working directly with patients had profound positive therapeutic effects on the patients, residents, or clients with whom they interacted. These persons might be described as health-engendering. Such persons did appear to be more intelligent, younger, and better educated than the average; significantly, they also appeared to talk more with patients about real life, not hospital life issues. They seemed to treat patients like people and were sensitive of their feelings. They appeared to recognize the effect that their behavior and attitudes had upon patients, and seemed to be quite aware of their own feelings toward patients and the reasons for them. Health-engendering persons appeared to have a positive attitude toward mental illness. They were not frightened by the idea of mental illness. They did not view it as incurable but were optimistic that patients might change.

It was also recognized by the planners that the success of mental health programs depends in large measure on the social context, and that the attitudinal atmosphere surrounding so-called mental patients can be a constructive factor in their treatment.

RATIONALE

In addition to the merging of these different streams of thought, other factors also contributed to the development of the Purdue Program and to the popularity of programs similar to it.

As several writers (Cohen and Struening, 1961; Gurel and Morgan, 1958; Levinson and Sharaf, 1958) have discussed, the nature and general level of patient care has changed markedly in the past ten to twenty years. There has been a growing effort to humanize the hospital and to raise the patient's general status in the hospital. Closed wards have been opened, various degrees of patient government have been introduced, recreational and work facilities have been improved. These changes have been carried through chiefly by non-professional or semi-professional personnel in the non-medical, paramedical, ancillary treatment departments, and/or the nursing service. The newer policies are not, for the most part, intended to induce major depth insights or personality restructuring in the patient. Their aim, rather, is to provide him with opportunities to learn through constructive activities and personal relationships. Terms such as "milieu therapy," "total-push therapy," and "sociotherapy" have been used to describe this development. This newer outlook is based on the assumption that the well-being of mental patients is influenced by the social climate of the setting. This social climate or context is the product of the attitudinal atmosphere created by hospital or institutional workers.

Ellsworth (1961) described a program which focused on increasing the schizophrenic's contact with others. More specifically, Ellsworth was concerned with supporting the psychiatric aide as an active participant in the patient's hospital life. The aide was helped to become an active participant in the decision-making process of granting privileges, planning activity assignments, planning for discharge, recommending ward transfer, and similar care and management problems. The main emphasis was upon selection and training of a person who interacted with patients in significant daily transactions. This program appears to have been dramatically effective.

The use of volunteers has made valuable contributions to the humanization and socialization of the mentally ill and retarded. The programs which have used volunteers in various special programs and have concerned themselves with the selection and training of volunteers are too numerous to mention. One interesting development has been the use of college student volunteers. The program at the Metropolitan State Hospital in Boston so delightfully described by Umbarger, Dalsimer, Morrison, and Breggin (1962) suggests that intelligent, enthusiastic, wholesome, young people have an impressive impact upon patients. It is the thesis of the Purdue Program that intelligent, trained, wholesome, people can have a greater impact if they are present in the patient's social context on a *full-time* paid basis.

Rioch (1965) trained a group of middle-aged housewives to be counselors and they turned out to be effective and sensitive therapeutic agents. Sanders (1965) at the Philadelphia State Hospital is successfully training four year college graduates to be socio-environmental therapists — the primary agents for bringing about an effective milieu in a large mental hospital. The Fort Logan Mental Health Center (1965) has dramatically utilized psychiatric technicians as full members of the therapeutic team. These persons with high school educations or the equivalent are given nine months of in-service training and they function as therapeutic agents in the therapeutic community.

These pilot programs have given us an exciting glimpse of what can take place when imaginative and creative approaches are well thought out and have the support of relevant professionals. They certainly suggest that many therapeutic functions can be accomplished by middle-level professionals when effective educational and supervisory systems have been worked out.

Not the least of the considerations leading to the development of the Purdue Program is the manpower shortage in the mental health field which is currently acute and which will become progressively more acute over the next ten to fifteen years (Albee, 1959). The enabling federal and state legislation of the past few years opens up an entire new area of employment and creates the potential for the employment of many new personnel. The extension of mental health activities into the community appears to require a corps of mental health workers who, in some respects, must have different knowledges, attitudes, and skills from those traditionally possessed by workers in the institutional setting. The proposed activities of a fully developed comprehensive community mental health center all require personnel for implementation. These activities include partial hospitalization (day, night, or week-end care), consultation with community agencies, rehabilitation services including vocational and educational services, pre-care, after-care, foster home placement, home visiting, quarter-way houses, half-way houses, sheltered workshops, out-patient services, compensated work therapy, emergency services, crisis intervention, "teacher-moms" for emotionally disturbed and retarded children, homemakers for families with mentally disturbed members, and a wide variety of other activities many of which are not yet imagined. The greatest bottleneck in the development of such centers is the personnel to staff them. The Purdue Project proposed to explore the utility of a training program to prepare persons for such activities. The Purdue Project is oriented toward preparing a generalist in mental health work. After his two years of training he may perform many general functions as a member of a therapeutic team. He may gain additional pre-service or in-service training in a wide range of activities, such as occupational therapy, educational therapy, recreational therapy, group therapy, work therapy, rehabilitation and other activities.

Another unique nature of the Purdue Program is that it is University based pre-service training. The current practice in the recruitment of the majority of the non-professional mental health workers is to employ and then to attempt to train them. In other words, on-the-job training has been utilized to provide workers with basic skills and techniques. This procedure has been moderately successful for some jobs such as that of the psychiatric aide. However, it has left much to be desired for several reasons. Anything that such personnel subsequently learn about the care and management of patients, they learn while they are earning a salary for the services they are rendering. There are a few exceptions, but often the service needs take precedence over the training needs. No generally accepted objectives or methods have been developed for on-the-job training programs. Most such programs are organized for psychiatric aides and place considerable emphasis upon nursing procedures. They seldom provide the learners with these skills and attitudes which should contribute to their comprehension of the meaning of observed behavior and the manner in which their behavior may influence the behavior of patients. An exception to these comments has been the Fort Logan program for the training of psychiatric technicians. Yet Fort Logan has arranged with a junior college for college based training for their personnel.

The National League for Nursing (1959) has described other disadvantages of on-the-job training and advocates pre-service education. Unlike on-the-job training, pre-service education is not slanted toward preparation for work in a single institution, but prepares for work in a variety of settings. The Purdue Program is designed to prepare a person for a vocation not for a job.

THE STAFF

Our staff does not include professional educators. I, myself, am a clinical psychologist who came to Purdue from clinical work. I am not a professional educator by background. Signficantly the other people on the staff of our program are also clinical workers by background. They all came to Purdue from the field where they have been working with patients; this is a very important point particularly when so much emphasis is on therapeutic relationships with patients. In addition to myself, the staff includes one other psychologist who is an industrial psychologist who does much of the research for the project. We have a psychiatric social worker who is a teacher on the program and is responsible for the development of the practicum. The fourth man on the staff has a Masters degree in recreation and teaches the students some of the activity therapy skills that I mentioned.

We therefore have inter-disciplinary staff to assure that our people are not going to become assistants to a particular professional. We want to guard against the idea that they are being trained or educated to become junior psychologists or junior social workers or junior anything. We want them to be regarded as professional people in their own right and to develop an identity about this vocation that is their own. This is one of the reasons that we have inter-disciplinary staff and I think that part of it is working out rather well.

THE STUDENT

We felt in the beginning that we wanted to look at three different areas for our students. First, as you might expect, the new high school graduate; secondly, psychiatric aides and other people who are working in the field of mental health and wish to advance into careers with greater rewards; thirdly, mothers who have already raised their children and would have time to help in mental health programs, but need some special training.

Our recruiting succeeded in getting people in each of these categories for our first class. This initial class which graduated this past June had 33 students; their age range was 17 through 52 years, with an average of about 21.7 years. There were five former aides in this group, two men and three women. The former aides were the only men in this first class. All the applicants were rigorously screened; they were given psychological tests and were interviewed in depth by several of our program people. They had to demonstrate to us that they were really motivated and that they were psychologically equipped to work with mentally ill patients.

The second class, was slightly smaller, the 30 students included four men and 26 women. The average age of 21.6 years was slightly lower than that of the first class. There were no aides in this second class although we did have two people who were former VISTA workers.

The difficulty we have found in getting aides into our program is frankly due to their family responsibilities. Most of them, and the men in particular, have to count on their paycheck to support their families. Unfortunately, as of now, we have not provided the means to support them fully while they are in school. However, we are working on a program that would permit them to continue to receive their full salaries or close to it while they are in school. This may help us get more people from the mental health system into our program. The third class which just started this September is larger than the previous two classes. Its 45 students include four married women and one widow. The age range in this class is 17 through 53 but again the average age is 21. The age level of our classes seems to be growing younger and younger.

I noted that Dr. McPheeters yesterday mentioned his concern in attracting new high school graduates into mental health technology. We ourselves are not experiencing any difficulty in recruiting high school graduates. We are having some difficulty in attracting the available and eligible mothers. I'm not sure what we can do to increase our recruiting efforts for these women who have done very well in our program.

We have the blend of the young person with their youthful enthusiasm, and the older person with more experience in living, as a very fortunate one for our learning program. The older person has developed a great deal of skill in interpersonal relationships. The two groups can help one another.

It is interesting to see how the younger people in our program would listen to the older students where they would not listen to their parents.

OBJECTIVES

What are our objectives and how do we attempt to meet them? It should be noted immediately that one of our objectives is to explore and develop a program; therefore, the nature of the training experiences offered to our students is always subject to change.

First, since our students will receive an Associate degree, the university has certain general education requirements which must be met. Over a two-year period, the students will earn six semester credits in human biology. They will earn fifteen credits in psychology. The specific courses currently required are Elementary Psychology, Child Psychology, Social Psychology, Abnormal Psychology, and the Psychology of the Exceptional Child. Six credits will be earned in sociology. These include an introductory course and a course concerned with social problems. In addition, the required curriculum includes a course in English Composition. These are chosen as standard liberal arts courses with emphasis on the development of a broad social-psychological base in the understanding of human behavior (see Table 1).

A second objective of the program is to develop certain attitudes and behaviors in our students. These are the characteristics previously described as health-engendering. We have frequently mentioned such terms as "social context" and "attitudinal climate." We wish to develop a frame of reference in our students so that they view clients, residents, patients, or other recipients of mental health services as people. We want our students to develop a healthy respect for other people. We want our students to have respect for themselves. We want them to believe that people, all people, including themselves, have the capacity for self growth. We don't attempt to develop these attitudes by giving lectures. We attempt to develop them by responding to our students as we expect them to respond to others. That is, we behave in such a way which demonstrates our belief that they have the potential for growth and that they have valuable contributions to make.

TABLE 1

Curriculum for Mental Health Technology

FRESHMAN YEAR

First Semester:	**Cr.**
BIO 201 Biology of Man	**2**
BIO 202 Lab. in Human Biology	**1**
PSY 120 Elem. Psychology	**3**
ENGL 101 English Composition I	**3**
MHT 110 Group Dynamics I	**2**
MHT 100 Intro. to Mental Health	**4**
	15

Second Semester:	**Cr.**
BIO 203 Biology of Man	**2**
BIO 204 Lab. in Human Biology	**1**
PSY 235 Child Psychology	**3**
SOC 100 Intro. Sociology	**3**
MHT 111 Group Dynamics II	**2**
MHT 101 Case Study Method	**4**
	15

Summer Session (Special Extended Period)

MHT 105 Practicum Work with Emotionally Disturbed 1

Third Semester:	**Cr.**
SOC 220 Social Problems	**.3**
PSY 350 Abnormal Psychology	**.3**
MHT 210 Group Dynamics III	**.2**
MHT 200 Activity Therapies	**.4**
Elective	**.3**

Fourth Semester:	**Cr.**
PSY 340 Social Psychology	**.3**
PSY 532 Psychology for the Exceptional Child	**.3**
MHT 211 Group Dynamics IV	**.2**
MHT 201 Learning Theory and Behavior Modification	**.4**
MHT 298 Seminar in Mental Health	**.3**
	15

This is a very abstract concept and perhaps can be clarified by an example. The Purdue Program is new and different. As far as we know, it is the first of its kind. As far as the staff is concerned, we and the students are partners in a new experiment. We expect them to have ideas which may be valuable to the project. We encourage their evaluations and criticisms and have used many of them.

This kind of climate is far different from most programs involving student-teaching relationships. Its development is related to a third objective of our program. This is the goal of developing interpersonal and intrapersonal sensitivity in our students. We attempt to approach this goal by a group dynamics or modified sensitivity training procedure.

Prior to the start of classes in the fall, students, staff and outside consultants spend four and a half days at a camp removed from the campus. The total experience may be called a laboratory in human relations training. Part of the days at the camp are spent in sensitivity training groups. In general, these groups provide experiences in social creativity. Ten to fifteen individuals are placed together and starting from an aggregate of strangers create their own miniature society with norms, goals, and roles. The groups focus upon this process and also upon individual member behavior. In the process of struggling with a seemingly agenda-less group, members strive to create a meaningful experience. As they do they exhibit behavior which is looked at by the group. At the same time, individuals have the opportunity to look at their own behavior and its impact on others. The attempt is to create a climate of trust, support, and openness so that individuals can see what kind of people they are and how others see them. Then, if they choose, they can try new ways of behaving.

I will try to reduce the abstractness of this description by examples. The beginning sensitivity group meeting is usually slow moving, stilted, and uncomfortable. Most persons look to the teacher or leader to supply the agenda. This leader does not do this, consequently members make attempts to structure the meetings and in the process behave as they might in the outside world. This behavior becomes the subject matter for the individuals and the group. Another example is what can be done with decision making. Rather than being lectured on the psychological dynamics of group decision-making, the groups are given decision-making tasks. After the groups have performed these tasks, their reactions and feelings are discussed.

In addition to sensitivity and training groups, the participants are given specific exercises. There are sessions on non-verbal communication, the helping relationship and one-way versus two-way communication. This training in group dynamics is then continued throughout the overall training program. Small groups meet twice weekly for the four semesters. Formal credit is given for these meetings by a series of courses entitled Group Dynamics (I, II, III, IV.) These meetings are led by members of the staff who have had experience with sensitivity training.

Without citing specific research results, the staff believe that this has been demonstrated to be an extremely effective procedure to begin to create the kind of attitudes and behaviors for which we are striving. Incidentally, we are collecting data which may provide experimental validation for sensitivity training procedures. Such experimental evaluation has not often been attempted. It is obvious to everyone that our program in total has had a profound effect on our students. We have, without doubt, a very unusual group of undergraduate college students. Visitors to our program are almost invariably impressed by the students' motivation, openness, insightfulness, and ability to ask meaningful questions. Unfortunately, at the present, we don't know what makes the program effective. It may be due, in part, to sensitivity training, but it could very well be some other aspects of the program, too. We don't even know if these attitudes and behaviors will necessarily make the students effective mental health workers. In any event, we do feel that we are involved in a very significant experiment in education.

Another objective of the training program is to develop knowledges about modern mental health programs and activities. To this end, a series of five courses are required. These included courses with such titles as "Introduction to Mental Health," "Activity Therapies," "Learning Theory and Behavior Modification," and "Seminar in Mental Health." These titles are not particularly descriptive, but the courses are designed to provide a broad content of information concerning the methods and procedures of modern therapeutic programs.

Still another objective of the training program is to provide all students with direct one-to-one experiences with patients, residents, and clients of mental health related facilities. In addition to classroom time, all students spend approximately six hours a week in practicum settings. Students are started in field work from the first week of training and continue throughout the two years. Starting students this early in such experiences is fairly innovative. Students are assigned to a wide variety of mental health settings. These include a hospital and training center for the retarded, children's homes, a geriatric facility, a day care program for the retarded, an adult psychiatric center, an after care program of a state hospital, and several other settings.

In the first semester students are assigned to two residents or clients and given one, very general, unstructured task: to develop a relationship with their client. The intent is to expose students to the variables involved in developing close interpersonal relationships. Other assignments are to focus on the facility: What its goals are, how it operates, what its services are, and its impact on its clients. These were to be learned both from the clients and the staff of the facility. Portions of class periods are spent on practicum reports. Students in the different settings report to the total class. The aim is to allow students to see, in addition to differences in setting, the similarities between settings.

We wish to learn, for example, that trust is a prerequisite for meaningful interpersonal relationships with all people, including the retarded, the emotionally disturbed, and the aged,

In succeeding semesters, students are involved in a variety of activities under the supervision of mental health professionals both from our staff and the staffs of the facilities. Some of the settings have students performing traditional roles. For example, they may work as teacher assistants under the supervision of special education teachers in classes for the retarded. At the psychiatric center, under the supervision of a psychiatrist, students take part in or conduct first contact and intake interviews. At the hospital and training center for the retarded and at the after care facility, students provide, under supervision, delegated supportive and educationed functions relevant to social habilitation and rehabilitation.

In addition to the practicum during the school terms, students spend the summer between the first and second year in intensive work experiences in mental health facilities. During the past summer our students were placed in such settings as the Fort Logan Mental Health Center, (Colorado) the Oaklawn Psychiatric Center (Elkhart, Indiana), the Fort Wayne Hospital and Training Center, the Institute of Living (Hartford, Connecticut), Jobs Now Project (Chicago, Illinois), The Devereaux Foundation (Devon, Pennsylvania), and the Dayton State Hospital, (Dayton, Ohio).

In summary the goals of the practicum and work experiences are (1) to expose students to *people* with mental health problems; (2) to aid students in developing skills in interpersonal relationships; (3) to help students gain some insight into the dynamics of institutions; (4) to learn to look at the similarities and differences across mental health settings; (5) to view patients, residents, or clients as people and not in terms of labels; (6) to have students work directly with or under the supervision of professionals and to recognize the attitudes and relationship skills used by professionals with clients, families, and colleagues; (7) to acquaint the student with services available in communities at large; and (8) to provide the student with knowledges so that he can facilitate the coordination of services to better serve client needs.

The final and most inclusive objective is to prepare a mental health generalist. Obviously it would have been far more simple for us to train persons for a specific job. It is our premise that any program which trains for a job is far too limited for the needs of the field. The current status of mental health programs is one of new and expanding programs and continual change. We have defined a mental health generalist as a person with a core liberal arts university level education with an emphasis upon the behavioral sciences and with specialized courses and field experiences related to mental retardation, emotional disturbance, community programs and social welfare. The mental health generalist must have positive attitudes, human relationship skills, sensitivity, and broad knowledges. Such a person will be the arms and legs of the professionals in a wide variety of mental health settings.

PROBLEMS

It must be obvious that any program which attempts to create a new vocation, in which the workers are trained as generalists to perform undefined functions in unknown settings, must be doomed to have many problems. The broadness and the general nature of our approach runs head-on into numerous frustrations. Many of these fall into the category of "environmental constraints". These are society's built-in resistances to change which can block innovation and therefore must be recognized and worked with if change is to occur.

One of the most significant constraints encountered to date is resistance to this new worker by existing workers in the field of mental health. The elements of this attitude cluster around the thought that "only we professionals can do it", whether it be psychological testing, case work, counseling or therapy. Professionals have been trained to feel this way through the long history of developing our respective professions. We have been pre-occupied with upgrading the standards of admission to our professional fraternities. Certainly there have been benefits to us in status and pay and benefits to the receiving public in terms of higher grade service. We want these benefits to continue.

Our position is that one way to have them continue is to have middle-level professional workers handle elements of those work functions which don't require a Master's degree, a Ph.D., or a M.D. The trained professional can then be free to concentrate on consultation, program planning, supervision, depth therapy, and research. It is frequently difficult to make this point effectively to those who have been preoccupied with upgrading traditional roles. Words such as "Psychotherapy," "case work" or "nursing care" have magical meanings to particular professions and make it difficult for their representatives to consider the possibility that pre-professionals often can perform the functions adequately.

Another constraining attitude cluster is the threat to job security. Some professionals apparently fear that they will be displaced or regarded as less essential in the work complex. Our traditional mental health setting was a highly secure, highly structured, hierarchial system based on the tradition of medicine. As we change to the team concept, anxieties develop regarding role-identification and job security. One result of these circumstances can be a jockeying for position by team members and the resistance to the entry of new potentially threatening team members.

A third attitude clusters about as a sense of shame over past performance. Many clinical workers are acutely aware of the crude discrepancy between how much help they would like to provide to clients and how successful they have been. To the extent that a painful discrepancy exists, there may be defensiveness about how well we do and a concomitant need to protect ourselves from the revealing of such inadequacies.

We need to do a more effective educational job with our professional colleagues if we are to be successful. The Purdue approach to resolving the resistance by professionals is a strategy of maximal involvement. Our hypothesis is that the success of the program is dependent upon the extent to which professionals collaborate in the training and utilization of the new workers. We have formed a fifteen man advisory board comprised of key local and state mental health personnel. We have established effective communications with a number of national consultants to broaden our conceptual patterns. We take advantage of every opportunity to bring resource persons into the classroom. Our students have worked for one semester blocks of time in thirteen mental health settings and a number of summer placements. Our students have turned out to be our best ambassadors. They are the "proof of the pudding."

However, we have made one grievous omission. We have depended too much on the involvement of "key" persons. We have not sold the program to the rank and file of workers in mental health settings where our students have not worked. We are attempting to rectify this omission which has created secondary resistances which we must now overcome.

A second problem area was that of recruitment. I have already mentioned some of our difficulties in recruiting older women whose children were raised or almost raised, and the need to provide financial support for people who were currently psychiatric aides with family responsibilities. I would like to mention some of the difficulties we had in attempting to reach high school graduates.

With the high school graduates we logically planned to go through high school counselors. We ran into constraints here which were new and surprising to us. We first sent a colorful and unusual brochure to all high school counselors within a radius of the Fort Wayne campus. Several months later we began to spot check the results with some personal visits to certain of the counselors. Almost without exception, they had not heard of the program and were not aware of the brochure. It was typically buried in a two-foot stack of "colorful and unusual brochures" from other programs. The counselor is swamped beyond hope with mass mailings. Personal visits and discussion have had more positive results, however, and have formed the core of our activities since then. Career days and special meetings with groups of interested students have also been utilized.

We encountered another constraint in this high school communication system. We were interested in the student from lower socio-economic conditions who, while talented, might not be considering college. We thought our two-year program plus N.I.M.H. scholarship support would be ideal for many of them. The constraints were twofold here: first, the counselors were in touch with only a small minority of this segment of students, and secondly, there is such demand for the promising students with the current war on poverty and civil rights climates that the promising student could easily receive support for four year educational programs. We worked on the problems by utilizing new avenues of reaching the students outside of school. We started through the Office of Economic Opportunity and found our most fertile contacts in neighborhood associations. Another potential avenue which we are currently beginning to use and appears promising, exists through the churches.

Another problem area surrounds the area of eventual job placement. Very few appropriate jobs existed in the mental health establishment when the Purdue Program was initiated since it was new and there were no workers at the level we contemplate. In the state of Indiana we have no appropriate job description. There appear to be job openings for our students in a few other states but appropriate job descriptions do not exist in most states. Such descriptions must be prepared and they must be for a generalist rather than for specific jobs.

Much of the resistance encountered in setting up formal job descriptions relates back to the professional resistances previously mentioned. Another issue concerns ever-tightening budgets and this interacts with the professionalism factor. Both psychologists and social workers have told us that they are sure the Purdue Program graduate can do many things now being done by their staffs as well or even better than the professional. However, they hasten to add that if they were given the choice as to spending money on professionals or on pre-professionals they would hire professionals.

We are confident that as the mental health worker proves his worth there will be employment for him We have had sufficient requests for our graduates to place our first two classes.

JOBS FOR GRADUATES

I'd like to tell you about the jobs obtained by our first class of graduates. It's important I think to realize what this class went through. They had to be the pioneers and go through a program which was not very well developed. They could not look forward to definite jobs when they graduated. Even in June when they were receiving their diplomas they were well aware of the fact that there were not clear-cut jobs for them out there in the big world.

We graduated 16 of the 33. There are 6 or 7 more who are still in school and are making up some courses. Of the 16 who graduated, 15 are working in mental health jobs which I would describe as good jobs. The girl who is not working in mental health, married and went to a small town in Indiana because her husband was continuing his college education there. Four of the 15 that were placed in mental health jobs are working for the state hospital. These people are employed in a job classificiation for a "teacher assistant," although they are not working as teacher assistants. They are actually working on units in hospitals for the mentally retarded doing behavior modification work and activity therapy work on the unit and performing a number of liaison or coordinating functions between units.

Two of our people have gone to Johnny Appleseed School, which is a day care center for the mentally retarded in Fort Wayne, and are functioning as teachers in the classroom there. Two of our graduates went to Ohio and joined a very excellent speech and hearing center. They are utilizing their interpersonal skills as speech and hearing technicians; they are being taught certain other technical testing skills which they can use in a speech and hearing setting. Another of our graduates has become executive director of the mental health association in our county. This is more of an administrative job but she does have certain supervisory responsibilities for after-care facilities and clubs for the emotionally disturbed.

Our graduates are working with a variety of problem people. One of our graduates is now in charge of a sheltered workshop for physically handicapped children. Another person is workin in a TB sanitarium where she combines some of the functions of a case worker with some of those of a recreation director. She helps develop therapeutic programs for the people at the sanitarium.

We have two persons who are working in an adult psychiatric clinic. Since they have just started work its too early to predict what they will be doing. Undoubtedly there will be some experimenting and exploration in the clinic to determine how best to use them. A child guidance clinic has employed two graduates; these people are functioning as full team members, performing the entire range of activities including intake interviews, and supportive therapy with children. The average beginning salary for our graduates was between $6,000 and $6,100 a year. We were pleased with this beginning salary, particularly since we had no idea what salary our graduates could command, since there were no job classifications for them. As a matter of fact this is a higher starting salary than that of associate degree nurses in Indiana.

The future job market for our graduates looks very good. Two developments contribute to this optimistic picture. First, we will have the state job specifications by the time we have the next graduating class, which will open the whole mental health system in Indiana to our graduates; secondly, we also will have the whole area of special education open to us. Corrections has also indicated an interest in taking our graduates. It now appears that within Indiana itself there will be a wide range of jobs for our people.

These will develop rather rapidly. We also find that other states have learned of our program and are coming in and actually trying to recruit our graduates. In general, we are very pleased with the favorable job market.

The broad areas in which our students are being educated and employed suggests to me that we probably should have a different name for them than mental health worker. I think community services worker, or something similar would be more appropriate since they are engaged, during their educational program in their jobs, in a wide range of community activities.

There are many unanswered questions about what we are doing and only time and our follow-up research will answer these questions. Such questions as: What will be the final acceptance of these workers by professionals in the field? What sort of future do they have in the system? Will we be able to work out ways of letting them continue up the ladder in the field of mental health or will they be "dead-ended" once they start working? If that happens are we back to the old problem that we had before?

We are also concerned with determining the impact they have on the different settings in which they are employed. We feel that the kind of attitudes and enthusiasm and education that they're bringing to the new settings may well provide some important changes within the setting itself. On the other hand since they are new and different they are also meeting resistance from existing workers. We will have to work with both sides of this coin to help existing workers accept the graduate while at the same time aiding the graduate to fit into the system. We need to continue to work on building a better bridge between existing workers in the field of mental health and our program so that it will be easier for them to enter our program, get some education and then go back to work in mental health. There is still much to be done in this regard.

The future looks encouraging. Early returns from our program and from the other programs which are starting around the country indicate rather clearly to me that we have an exciting new venture in mental health education which I think is going to have important implications for all of you.

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PSYCHIATRIC TECHNOLOGY AND MENTAL HEALTH MANPOWER PROBLEMS

by Willis H. Bower, M.D.

Dr. Willis H. Bower has been director of the Arizona State Hospital in Phoenix, Arizona since 1967. Prior to his present assignment he was deputy director of the division of research and training, in the California State Department of Mental Health.

Dr. Bower is certified in Psychiatry, American Board of Psychiatry and Neurology. His professional experience has been obtained in private and public hospitals and in private practice. These include, McLean Hospital, Belmont, Massachusetts, San Quentin Prison, California Department of Corrections, San Francisco City and County Hospital, Colorado State Hospital and the Neuropsychiatric Institute, University of California, Los Angeles.

His professional publications have primarily dealt with the use of drugs in the treatment of psychiatric illnesses and the development of a therapeutic community in a mental hospital. Other publications have presented imaginative new approaches in mental health treatment and policies.

I was pleased to be invited to come here and talk to you, but did not find it easy to decide what I could say that might be worthwhile for you to hear. I am not sure that I have decided well. But I will try to talk about aspects of the problems of psychiatric technology that I think I know the most about and I will try to deal with matters that seem to be of most importance at this moment.

I will speak from the point of view of a hospital superintendent: one who has the responsibility of making a program run. I find myself grossly dissatisfied with much in the general situation with regard to manpower. The basic problem, to my mind, is the nature of the care to be given to the patients. By this I mean, which persons, and in what arrangements, will give patients care.

I would expect that your problems and viewpoints are closely related. What I am going to say is this: from my viewpoint, this is how I would expect that things would look to you.

INTRODUCTION

We can assume that changes in mental health programs are bound to affect you; these changes are becoming more numerous and more frequent. These changes include changes in the training of psychiatric technicians that have been proposed and experimented with in various parts of the country. You have been interested in all of these things. You not only want to be kept informed, but also to participate in the process of change — to have some voice in what is going on.

But what seems to have happened lately is that someone moved the kettle from the back burner to the front burner. Now you have less chance to think things over at leisure, less reason to entrust your fate to other people, more reason to take a part in what is going on. Too many cooks spoil the broth, but I think you had better be sure you have your own cooks in on this, and that if someone is going to be crowded out of the kitchen, it had better not be the psychiatric technologist. Now let us turn away from the kitchen analogy.

Psychiatric technology was born in the public mental hospital. I don't know when the term "psychiatric technician" was first used and in what place, but the occupation emerged as something distinct and defined during the late 1940's and early 1950's. One after another, hospitals and states started training and using people who were psychiatric technicians or something similar. However, some states have not yet started this. The invention of psychiatric technology meant the transformation of a forerunner occupation composed of people chosen and trained "hit or miss," and without distinct standards, into an occupation with proper qualifications and ethical and educational standards. Your occupation was mostly brought into being by the nurses who trained the technicians; this tends to give your training a strong resemblance to nursing. Your roots are, therefore in the large mental hospitals.

THE CHANGING SCENE

But now a change is coming to the way psychiatry is practiced in public institutions. In the late 1950's pronouncements were made that the large hospitals were going out of fashion, and would be replaced or supplanted by other small organizations close to where patients live. The earliest significant legislation that I know of to promote this change was the Short-Doyle Act in 1958 here in California. Community psychiatry, as it is called, has, you could say, been tooling up since then; now, it is ready to go into action. The new California legislation of the 1968 session drastically changes the method of funding, so that the communities now have the option, at no monetary penalty, of keeping their own patients near home for care and treatment rather than using a state hospital.

As one person has so well put it (I believe the statement is properly attributed to Mr. Harris E. Hogan, Director of State Relations, California Association of County Supervisors), the patients before this time have gone where the money is — that is, to the state hospitals. Now with the new system, the money must go where the patients are.

Let me restate that a little — the patients have been going where the psychiatric technicians are and, of course, the psychiatric technicians are in the state hospitals. Now, with the new legislation, the psychiatric technicians will have to go where the patients are. This is an immediate problem in California. It will be a problem in other states soon, because I feel sure that other states will follow suit as the California experiment becomes generally known.

This will probably involve not so much any immediate changes in the essential work to be done, despite many opinions to the contrary — as a change in where the work is done. The places and some of the working conditions may be quite different. If you see a patient where there is no seclusion room you will not be able to succumb to the temptation of putting the patient in seclusion. Maybe you will work where there is no nurse in charge but instead, you may have other members of a team and a community to deal with. So, there will be differences in dealing with patients, both as to location and types of buildings, and as to personal relationships, that is, different bosses, different fellow-workers, different rivals, and different opponents. There will also be some differences in what you do and the kinds of patients you deal with.

This is an exciting and promising change that we see coming in psychiatry. The trouble with it for you as a psychiatric technician is that it comes at a time when you are trying to settle quite a number of other exciting and interesting problems.

To be able to do something about these different problem areas, they will first have to be summarized and put into the form of specific issues that someone can study and make decisions about. The issues will not resolve themselves. If you leave them for someone else to resolve without consulting you, I do not believe they will be resolved altogether in your favor. You, as organized mental health workers, will have to make known your views, your wants, and your demands. You have full and proper reasons to make yourselves heard; it is to you that the care of patients is directly entrusted, you must have ideas about how the care ought to be carried out.

IDENTITY OF PSYCHIATRIC TECHNICIANS

Who are psychiatric technicians – what kind of people are they? What do they do? Who are these people who take care of mentally ill persons – that is, those who take care of them most directly? These questions are the ones involved in what we have to call the problems of identity. They are the questions of defining psychiatric technology.

The problem of stating what you do seems easy at first glance, then on second glance it becomes more difficult. Psychiatric technicians take care of patients who are mentally ill and mostly in hospitals. So far so good, but there are some questions which complicate this statement. Do psychiatric technicians do what nurses do: give medicines and render those other treatments peculiarly the province of nurses? When they do they tend to become "junior nurses".

Some believe that the whole idea of a separate category of psychiatric technicians can be scrapped and that, instead, there should just be licensed vocational nurses with some psychiatric experience and training added on later. This concept almost took hold in California and I am not sure you are safe from the possibility yet. The question about whether you are a branch of nursing is answered differently in different states. In California the "junior nurse" idea is still quite a bit in the picture. There is a big advantage to the administration of hospitals if psychiatric technicians can give medicines and do so legally. A good many states allow this, but Arizona doesn't. When we first learned about it, this seemed a crushing problem, but then when one begins to build around this created difficulty, it isn't so bad. It forces the psychiatric technicians to be something other than a "junior nurse". It forces the nurses, both psychiatric nurses and general duty nurses, to clarify their own roles, since they no longer can pass along certain nursing tasks.

I think you as organized psychiatric technicians are going to have to set forth a policy about this; you either are junior nurses or you are something different. If you don't have a policy about it, others will decide it for you — and from their own viewpoints.

The next complication to the simple problem of identity is to what extent do you do some things that social workers do? Do you help patients make arrangements for discharge, or do you go back to giving baths and taking temperatures, and let someone else make the arrangements with the outside world? If you want to do these things, you will have to say so in organized policy statements. I don't think you have a leg to stand on in any claims you might want to make about being a distinct group who are not junior nurses if you don't do this. It becomes particularly important when you want to go into community work, because techniques of taking temperatures and giving shampoos have less value, while the ability to deal ably with a patient's employer is a premium skill.

There is another complicating question: Do you actively participate in compiling the information about the patient that is used in his evaluation? Do you also actively participate in the processes of evaluating the patient and deciding on his course of treatment? If you don't, you are underlings; if you do, you can properly be called members of the team.

More confusing to me is the problem of specialization. General psychiatric wards require skills that are probably considered the most central or typical of the psychiatric technician's role. Some of the specializations, however, seem to take you into fields of activity that are quite different from those of general psychiatry. Examples of such activities include caring for young children on a ward for the markedly retarded, and caring for bedridden senile patients. Sometime you will have to have a policy about whether general psychiatric work and specialties such as I mentioned are to be essentially the same with specialty training added on, or whether they should be different from the start.

There is a still tougher problem about specialties. How do you regard psychiatric technologies that grow up in places and areas of activities out of touch with you? These include, for example, programs that train middle-aged housewives to be psychotherapists, and the behavioral analysts such as those we have in Southern Arizona to do specialized work with school children. At first these people may not seem closely related to your concept of a psychiatric technician. But if psychiatric technology does not try to encompass them, the field may become composed of splinter groups that will be hard to deal with. I suggest that you invite these people into your meetings and councils early.

Don't feel too lonely nor put upon in this problem of identity. Others have to go through it too. As you probably know nurses have their own problems of identity, and periodically go through the pain of figuring out where they stand on matters related to their profession.

So much for the problem of identity. It is basic to the other problems and the answers to the others will come easier if the issues about who psychiatric technicians really are and what they do is worked out first.

RELATIONSHIPS WITH OTHER DISCIPLINES

The problem of relationships with other groups is part of the problem of identity and must be dealt with. Your central role of direct care of the patient requires that you establish good working relationships with other professional and occupational groups who also deal with mentally ill people. I will not go into all of these, because the list would be too long. However, the other groups you work with most closely also give rise to the greatest problems.

Your working relationships with physicians probably present the least problem. Since most places where you will work have clearly outlined responsibilities to patients, their treatment and decisions to be made about them, there are fewer problems of relationship to be worked out. Your main task is to get these doctors to recognize who you are and what you ought to be doing. You can't just leave it up to them; you will have to help them know you.

The relationship with nurses is, on the other hand, a difficult problem. This group gave your young occupation its first well organized education and standards for high quality work, therefore, nurses deserve to be kept in good and productive relationship with you. However, this will not be done without strain, because, as you grow and flex your muscles and take stands, conflicts arise. I have already brought up the problem of whether psychiatric technicians are junior nurses and I sincerely hope that you decide not to be. Besides your role problems you will continue to face the problem of supervision. On the one hand is the rule which specificies who supervises whom. On the other hand is the question of who, and in what respects, would be best qualified to give such supervision.

TRENDS IN EDUCATION

The arrangement of the educational process, the curriculum, is probably a matter of foremost concern to people throughout the country who are interested in training mental health personnel. The issues are several: How much education, what subject matter, how much specialization, and by what ladder may one climb? The junior colleges throughout the country have seized upon the possibility of educating psychiatric technicians and are developing a variety of programs. These are mostly associate of arts degree programs with similar curricula that emphasize social studies, nursing and related studies. They prepare for the practice of psychiatric technology in a general way. Unfortunately the programs are new and untested; we will have to see whether they attract and turn out suitable people who will work and stay in the field. Another difficulty is that we don't know how they will fit into the general educational scheme, and how they will be integrated with other training programs.

At some point you will also have to come to grips with the question of qualifications for entrance to training for psychiatric technology and the wages to be paid on completion of training. If the work isn't dignified enough, if it is too demeaning, people won't go into it nor want to stay in it. If the pay is too low, people will not find psychiatric technology as attractive as opportunities in industry. Psychiatric technology won't have enough people to draw upon if these things aren't taken care of.

ADVANCEMENT

Next is the problem of methods of advancement. What ladders are there to climb?

For centuries it has been traditional for men to prepare for a specific occupation and remain in it for the rest of their lives; the principle exception was the soldier, who usually went back to doing something else after his military career was finished. Thus in our own culture in past centuries, peasants remained peasants, noblemen stayed noblemen, and shoemakers learned their trade and never thought of learning another. The idea was to develop a finished product after a period of training or apprenticeship. It used to be that one was actually born into one line of work and one station of life or another. But these barriers have come down during the past few decades. Now one is allowed to make the best he can of himself. This is a national ideal and America prides itself that its citizens have equal opportunities. There are, however, barriers of a different sort. Although society itself does not set rules restricting you to any particular station, there are barriers in the inflexibly arranged educational processes which can restrict you from moving from one career step to the next. Most education of a technical nature beyond the basic and general loses its transferability. A nurse with a good three year diploma education tries to transfer this into college credits and runs into all sorts of trouble.

When college programs are set up for you, whether for one or two years, some credits should be applicable to any later programs of training that you might choose to enter. Some may want to continue into nursing. Some may choose to complete four years of college in order to go into more advanced or more specialized training in mental health work. These aspects of programs of instruction have not been resolved.

ACCEPTANCE IN PSYCHIATRIC TECHNOLOGY

The general acceptance for your specialty is also a problem. The place of psychiatric technology is well established in the civil service job specifications of several states. This constitutes a pathway of entrance into these states' services. However, this acceptance does not extend to local government systems. How then do you get the counties and municipalities who are to run the new local mental health programs in California to set up similar job specifications? I suppose you would do this by getting the large political entities to recognize you. Perhaps this is the biggest job you have at this moment. It requires the inclusion of specific duties, qualifications, and education into a package that is not only agreeable to you but that can be accepted by your prospective employers.

MENTAL HEALTH MANPOWER: THE LARGER PICTURE

In your absorption with the details of your own problems, you must not lose sight of the big picture in mental health care. It is often a difficult and confusing picture that is presented, so I have waited until the last to try to deal with it.

It has been realized by a series of observers from entirely different vantage points that there are not enough people with post graduate education to go around – that is, not enough psychiatrists, psychologists, nor social workers, the professionals who traditionally make decisions about what happens to mentally ill people. It is next pointed out that no serious effort has been made to fill this gap with properly trained college educated people. One proponent of a particular approach suggests a solution by comparing school teachers with the type of person who should be developed to do the broad general work with troubled people. Since we entrust the development of our children's intellects to these teachers with their bachelors degree education, a similar thing should be done with the whole business of helping people with troubled emotions. The doctors degree and masters degree people could then take their places as consultants and as special problem workers. But, please note that now we are talking about two years more education than what has been thought of so far for training psychiatric technicians in associate arts programs. What I am trying to point out is that the problem of how to take care of the troubled and ill people, wherever they are, extends far beyond the problems that seem to be of more immediate concern to you, and that a lot of thinking is going on in trying to work out new solutions. Psychiatric technology should keep itself attuned to this larger picture, even though this is difficult when there are more immediate problems attracting your attention and consuming your energies.

THE MENTAL HEALTH TECHNICIAN: MARYLAND'S DESIGN FOR A NEW HEALTH CAREER

by Robert M. Vidaver, M.D.

Doctor Robert M. Vidaver is Director of Psychiatric Education and Training with the Maryland Department of Mental Hygiene.

He obtained his medical education at Columbia College in New York and the State University of the New York College of Medicine. His internship was taken at the University of Maryland Hospital. For his postgraduate training in psychiatry, Dr. Vidaver went to Yale University. From 1962 to 1966 he was a candidate of the Baltimore Psychoanalytic Institute. He is a diplomat of the American Board of Psychiatry and Neurology.

Prior to assuming in 1965, his present position with the Department, Dr. Vidaver was instructor and then assistant professor in the University of Maryland Department of Psychiatry.

The professional papers published, or in process of publication by Dr. Vidaver, reflect his wide range of interest in psychiatry, mental health manpower, and education in mental health. Of particular interest, in connection with the theme of our convention-institute are such publications as: "The Manpower Deficit in Mental Health," "The Regional Approach to Allied Health Education," and "A Regional Health Sciences Institute: A Proposal for a State-Wide Consortium " Publications in preparation include: "Undergraduate Education in the Allied Health Sciences," "Professional Identity Through Group Processes," "Mental Health Training in a Community Context" and "The Allied Health Sciences College: The Relationship of Social Role to Funding Sources."

His unique knowledge of mental health education and training places him in great demand as a speaker and advisor. This is also reflected in his membership on such boards and committees as the Advisory Committee to the Community College of Baltimore Mental Health Technician Curricula, Paramedical Advisory Board to the Essex Community College, Advisory Board to the Southern Regional

Education Board's "Community College Mental Health Worker Program" and Maryland Governor's Committee on Social Welfare Manpower.

The Maryland Department of Mental Hygiene, in search of solutions to the crisis in skilled manpower for the care of the public mentally ill, and in awareness of the several pilot programs underway nationally, sought, in 1966, to directly implement initiation of a new kind of mental health worker at the "associate" professional level.[23]

HISTORICAL REVIEW

The concept of associates to the traditional mental health disciplines has long been with us; records from the Henry Street Settlement House and Hull House indicate supportive activity by paraprofessionals. The Menninger Foundation developed an impressive curriculum for hospital aides during the 1940's, emphasizing psychodynamics and, implicitly, future career opportunities.

Our military services have developed a spectrum of ancillary medical corpsmen, including mental health. In the 1950's, Col. Albert Glass demonstrated the practicality of "non-Professional" psychology and social work enlisted technicians, particularly within a community mental health context.[1, 9]

Several State hospital systems, California and Maryland amongst the more notable, have, for more than a decade, trained advanced psychiatric aides (technicians) at a level clinically analogous to the licensed practical nurse. Schleifer, and his associates at the Crownsville (Maryland) State Hospital, in 1960, selected advanced aides for a variety of simple professional tasks under close supervision; this group creditably interviewed patients and their families and worked with outside agencies.[18]

Using training approaches previously reserved for psychiatric residents,[17] Flint, Rioch, et al, at the National Institute of Mental Health developed through a two year program qualified psychotherapists from mature housewives. Elkes, Stone and Godenne have successfully graduated their first class at the Phipps Clinic following a parallel design; Davidson, at Sinai Hospital (Baltimore, Md.) worked along similar lines with hospital volunteers.

ENTER: THE COMMUNITY COLLEGES

Not until the advent of the Purdue program under True's direction, however, has an associate professional career in mental health been elaborated within the mainstream of American collegiate education.[20] The importance of this event should not be underestimated; without the fortuitous evolution of the community college movement, with its dual emphasis on vocational training – terminal curricula – and upwards college transfer, we should yet lack that vital link which makes feasible any joining together of in-service clinical competence with the inherent career advantages of the collegiate experience. For the first time training in *beginning* professional skills could be combined with traditional liberal arts coursework leading to an associate of arts degree and insuring for graduates relatively open-ended educational and occupational futures.

Area-wide conferences by the Southern Regional Education Board, in 1966 and 1967, led by Drs. Mc Pheeters, Penningroth and Bramlette sparked further enthusiasm and intra-state collaboration by bringing together both State mental health leaders and college educators.[19]

Following the 1966 Atalnta SREB conference, Catonsville Community College and the Maryland Department of Mental Hygiene initiated curriculum planning.[4] By 1967 Catonsville and the Community College of Baltimore (1967-68)[6] were working with their first freshman classes; Essex Community College has modified, effective 1968-69, an older Social Service Assistant curricula to the technician design.[8] Anne Arundel Community College and Montgomery Junior College are in the process of curriculum design, and anticipate inauguration of programs by September, 1969.* Since 1967 Towson and Coppin State Colleges, four-year liberal arts State Schools, have also worked closely with both the Department and the Maryland community colleges in exploration of parallel four-year curricula for mental health counselors and maximal transferability of A.A. degree credits.

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*Successful development by the community colleges of A.A. programs in nursing, in the years immediately previous, had testified to the feasibility of training

INDIGENOUS HEALTH WORKERS AND THE "NEW CAREERS"

Fortunately, in the years immediately preceding crystallization of the Maryland programs, the effectiveness of indigenous mental health workers had been amply demonstrated by Pearl at Howard University (Washington, D.C.),[11] and by Riessman, Peck, Hallowitz, Roman, Kaplan, Jacobson and Boyajian in their monumental Lincoln Hospital project (Bronx, N.Y.) [12,14]

Pearl and Riessman rediscovered, as it were, in "New Careers," a new manpower reservoir in the poor. More importantly, they achieved a major theoretical breakthrough in perceiving that community mental health care deriving out of indigenous leadership is, and of necessity must be, a vastly different clinical "organism" than that stemming from professional origins; they are born of different training, perspective, values and personal needs.

Also acknowledged by the Maryland planners was VISTA's success and the effectiveness of the Nation's Community Action Agency center, [13,16] staffed, to a considerable degree, by associate professionals, trained primarily on-the-job, yet today working under the direction of both traditional professional supervisors and leadership from out of their own ranks.

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young people, in large number, to entrance levels of competence in the health field within collegiate type environments, augmented by practicum assignments. Daytona Beach, Miami-Dade, (Florida); Sinclair (Ohio), Metropolitan State (Colorado) and Central YMCA (Illinois) have also subsequently instituted mental health technician programs, at least in part stimulated by the SREB.

CAREER LADDERS

Fourth, and lastly, the Maryland program owes theoretical debt to the "career ladders" principle. Repeatedly incorporated into Federal legislative guidelines and actively disseminated by N.Y.U.'s New Careers Development Center, "career ladders" stresses open paths for both lateral and vertical mobility, actually built into institutional personnel policy.

A COMPREHENSIVE PLAN FOR MANPOWER DEVELOPMENT

The Department espouses five explicit manpower goals: (1) for professionals, more efficient deployment; with (2) associate professional augmentation of professional staff; (3) development of new manpower resources, particularly through remedial and habilitative programs; (4) "open-ended" career advancement available to all employees, either through continued education or work-study program and, (5) wherever practical, restructuring Departmental schools in partnership with appropriate collegiate institutions, with all curricula culminating in certificates or regular degrees.

PEDAGOGICAL DESIGN OF THE TECHNICIAN CURRICULUM

We began on a simple thesis: we believed the community colleges capable of training *"beginning"* professionals for a variety of entry roles in human behavior services without years of preliminary higher education; we believe they can do this without compromising either the quality of patient care or our students' future employment, educational or professional opportunities.

"Beginning" professional is used advisedly; it presumes the availability of professional guidance to young technicians, plus something more: the unshakable faith by technician and institution alike that — with time — professional skills and status will be achieved. Assignments and responsibilities, at first undemanding, would thereafter grow in proportion to an individual's own acquisition of maturity and clinical experience.

Besides an all-too-limited exposure to college English, humanities and a physical or biological science, the main body of didactic content emanates from the social sciences — anthropology, psychology and sociology, urban affairs and political science. (See Table No. 1)

Nobody advocated seeking after "instant" professionals via miniaturized carbon copies of traditional graduate curricula. Innovation was in order. Design of the technicians' practicum experiences and interrelated Mental Health Technology courses assumed highest priority. Observational experiences in diverse mental health facilities needed early introduction and continued emphasis throughout, with the addition of supervised clinical responsibilities the second year. Top-notch practicum follow-up of the initial social science content seemed essential to any functional synthesis of both practicum and campus learning.

The teaching of intepersonal skills and the faculty's focus on the students' search for self-awareness were reserved for the smaller group-type seminars which are more suited to "role" playing, psycho-drama and the public exposure of personal observations and feelings. Reading and lecture materials were planned to parallel the seminars, and would introduce psychodynamic issues, communication theory and group process, as well as studies on the dynamic interplay of social, familial and developmental factors in the genesis of human behavior, and affect and personality organization.

Practicum hours are supervised by mental health professionals of the several disciplines. Clear and open communication between college faculty and clinical staff is repeatedly beclouded, is talked about, and is briefly renewed; in this kind of endeavor there is no "solution," and liaison becomes a "way of life."

In addition, we expect the technician students themselves will interject into the curriculum much of its most valuable content, through feedback and reaction to the present format, and through the medium of their own group interaction. Peer-group learning and peer support will likely modify and mold their professional "identity" – their ways of doing things with patients. Beginning with a student's handling of "role-playing" exercises within their group and further refined in relation to peer responses during presentation of their own taped interview material, the technicians contribute considerably to their own education and professional value system.[15]

The last semester's practicum will include the chance to assume minimal but clinically meaningful duties within a single agency; the students will participate as "working" members of ongoing mental health teams.

The sum of each student's practicum rotations will represent but a fraction of the total available sites. In the ensuing exchange of personal experiences, classmates will add to their communication skills and ability to define agency or program objectives.

Summer employment in the human services field is strongly recommended between freshman and sophomore years. No practicum could ever duplicate the inexplicable realities thrust upon one by a "real" job. Then too, employment is an opportunity for a mid-way reassessment: "Is this the work I want for the 'rest' of my life?" Summer employment affords the students, many yet teenagers, a more realistic vantage point from which to continue technician training, or to entertain another career choice before losing significant college credit.

Each of the three Maryland curriculums is roughly comparable, yet with its own distinct structure and clinical philosophy. Standardization has been avoided; flexibility in response to future experience and the freedom to innovate are highly desirable, especially during the first stages of a "new" career. Potential "sub-specialization" by one or more of the colleges remains conjectural, although the Department would like to have the community colleges offer, periodically, special "continued education" courses to graduate technicians, and others.

Field assignments are many and varied. They include inner city health and mental health centers; facilities for the retarded; selected State hospital areas; correctional institutions and the training schools; alcoholic and addiction units, and those specializing in the care of the aged and chronically ill. Two prestigious university psychiatric facilities are represented, as well as a "store-front" church, and community action and neighborhood childcare "activist" centers.

THE STUDENT BODY

About seventy freshmen and a handful of upperclass transfers were enrolled during 1967-68; a similar sized group is anticipated to enter the three operational programs – Catonsville, Baltimore and Essex Community Colleges – in 1968-69. Most of the technician students are full-time. A few working persons, housewives and Departmental employees, have also participated on a part-time basis.

A Departmental work-study program, inaugurated in 1968-69, will allow up to twenty employees to enroll full-time, while being continued at full pay during their two college years. We are sanguine that Departmental employees will contribute meaningfully to the overall educational "input" through their longstanding acquaintance with patient care, even as, hopefully, some of the youngsters' enthusiasm for the nontraditional will "rub-off" on our own.[14] Our employees are knowledgeable concerning the longitudinal course of mental illness and the long-term effects of "institutionalization"; this expertise should amplify classroom discussion and afford a very different perspective of a program's effectiveness than the students would ordinarily receive from their contact with professionals during practicum assignments.

Technician students from each of the three active colleges, are, in general, a representative cross-section of their own college population, although differences between the colleges in socio-economic, racial and religious characteristics reflect the city-suburban dichotomy typical of the Northeast's cities. Taken as a whole, however, particularly after the inclusion of the Department's work-study group, the technician students average out to a more balanced cross-section of the total Maryland population. That the sum of graduate technicians will be an heterogeneous and fully integrated group is no accident, but represents studied administrative design further implemented in the pooling of practicum and summer opportunities amongst all three schools.

Tuition averages $125 per semester, and covers only 15-20 percent of the educational cost; the remainder is provided from State, county (or City) funds. None of the Maryland technician programs, to date, has specifically received any NIMH or other Federal research, pilot program or special educational (Title I) grant funds. Aside from minimal Departmental monies (approximately $12,000 annually for years 1967 and 1968 only) total support has been through routine community college budgeting.

TECHNICIAN TRAINING: WHAT ARE THE CLINICAL GOALS?

Extrapolating forward in time on the basis of college curricula, practicum focus and a nascent "esprit" seemingly shared by students, planners and college faculty, suggests, perhaps, a dozen clusters of interrelated job activites. Most of us would anticipate at least rudimentary professional skills in the following:

(1) *Interviewing Techniques* — in observing behavior, and interviewing. It would prepare the student to: talk harmoniously with others towards a clinical purpose; expeditiously elicit information, without emotionally harming the patient or client; collate and synthesize its substance; and effectively communicate selected portions to colleagues. In observing behavior and eliciting information the student would try to be aware at all times of the impact of feelings, institutional (neighborhood) pressures and the larger culture upon the entire process.

(2) *Consultation Techniques* — to prepare students to help people — patients, families and organized groups — find solution to an immediate dilemma in such fashion as to mobilize their own skills and to permit them to generalize the solution to future situations of a similar nature. For instance, he should be able to help a family find the answer to its own question when it asks, "And when he finally does get home, how should we 'act' towards him?"

(3) *Group Dynamics* — in understanding the theory and practical leadership involved in diverse group work. For example,

technicians might lead a continuous group for mothers of disturbed children or apply principles of group process to the umpiring of a training school ball game.[3]

(4) *Community Action* – This would show the student how to utilize available community structures and values systems, and, in concert with intrinsic leadership how to develop tactics effective in awakening a community's dormant resources towards the amelioration of its common afflictions. In this role, technicians would also bulwark anti-poverty, welfare, juvenile services and other related State agency manpower capabilities.

(5) *Sensitivity to Effects of Chronic Illness* – Through routine confrontation with chronic illness – unremitting schizophrenia, the aged, alcoholism, retardation, degenerative neurological disease – technicians will be knowledgeable in the reciprocal debilitation of chronic illness upon both the patient and his family, or their institutional surrogates. Perhaps future technicians will be "free" to assume unorthodox roles in the care of chronically ill peoples, proud roles, divorced from social and professional opprobrium – that are tolerant of dignity in the dying.

(6) *Teaching* – Through training in "how to teach," practiced teaching before their peers, and familiarity with audio-visual equipment, technicians will qualify in the instruction of other personnel, volunteers, patients, student visitors, and community groups. Most importantly, as members of college "teaching teams," they would participate in the education of future technicians.

(7) *Behavioral Modification Techniques* – After participating in a plethora of Maryland State Hospital pilot programs, graduate students could participate in the support of similar investigative work and its application to patient care.

(8) *Liaison Techniques* – Technicians could be prepared to act as expeditors bridging the interface of administratively independent, but "functionally" articulated clinical units – a hospital adolescent ward and that community's high school, for example.[5] They could serve as "ombudsmen," to mediate between those needing help and the appropriate agencies or professionals.

JOBS NOW!

Concomitant with the earliest college curriculum planning, the Department sought to establish a permanent job classification and career "series" within Maryland Civil Service. College collaboration and the recruitment of "good" students are realistically achieved only when actual jobs, pay scales and career opportunities are clearly visible, preferably long before the first class enters. A sense of continued acceleration is required in the initiation of new and unorthodox programs; administrative and professional inertia weigh heavily and the zeal of early supporters is rarely rekindled once momentum falters.

Mental Health Technician I positions are fully authorized now; anybody graduating today could be hired by any of the Department's hospitals or community health centers. Pay begins at $5,925; annual increments brings this to $7,783 in six years — even without promotion to Tech II. Current proposals recommend advancement to the Technician II level upon successful completion of any one of a variety of one-year in-service programs keyed to the special clinical "know how" required in their regular job assignment (child care, retardation, community mental health, as examples). Most technicians would be paid, after their first year, at the Tech II, $6,518 to $8,562, salary scale.

Employment within the Department would be either in our emerging community mental health centers or the larger state hospitals complexes; the latter are gradually being unitized on a geographic basis.

Work in the community centers, themselves profusely nontraditional and without long-standing structural traditions, will pose less problems in role conflict and assimilation. In the older hospitals they will be initially deployed, in groups, on "model" units chosen for the technicians on the basis of their known leadership and flexibility and, above all, their specific requests for technician manpower.

Rather than being assigned to any of the professional departments (i.e., nursing service, psychology, social work, etc.,) technicians will be administratively under the program, unit or ward chief responsible for the area in which they are working; they will take direction from the program chief along with their colleagues from the other disciplines. The unit chief knows what he wants done, knows the capabilities of his staff and is best able to assign priorities for activities in relation to the unit's overall program goals. We believe this will allow the technicians to most rapidly identify with, and understand, the institution's general responsibilities and service objectives; – they would not be limited by the professional perspective of a single discipline.[18, 21] For this reason, and to diminish the inevitable rivalries and pressures tending towards role diffusion, we would take strong exception to any apprenticing of technicians for work as "assistant social workers" or "assistant rehabilitation therapists." No doubt young technicians will be called upon to support the professional efforts of all the traditional disciplines; many of their roles could justifiably be termed "beginning" social work or psychology activities. None the less, such an "assistant" category, administratively sanctioned, would thwart evolution of an independent identity and lead to permanent "second-class" status.

Utilization of technicians on "therapeutic teams" and in areas using a community-milieu approach to patient care will be given initial precedence, on the assumption that where all disciplines are already working together towards common clinical objectives under unified leadership, they will find it easier to gain acceptance on their individual "merits."[2]

It will not be easy; we anticipate problems with institutional "cliques," with educational "purists" and with the lower echelon personnel. There will have to be compromise, if the technician program is to succeed. However, it is the young technicians who will face the greatest challenges. Each will have to struggle to find for himself, from a position at the bottom of the professional "totem pole," both an institutionally acceptable identity, and a purposeful, helping role towards his patients. Under these conditions it will be critical to sustain peer group relationships and the continuity of their own self-image.

THE ASSOCIATE PROFESSIONAL CONCEPT

As a means of developing qualified manpower, the associate professional concept is predicated upon two premises: (1) that associate professionals are beginning professionals, inherently capable of growth to full professional competence, provided, (2) that supervision and continued educational programs of quality are readily available during those years of personal metamorphosis. Graduate technicians should be considered neither finished professionals nor perennial subordinates. Although we are not grooming them for any single specialty role, we anticipate that, once they are employed, there will be a gradual narrowing of clinical focus, according to their personal predilection and institutional requirements. This presumes that provisions for both step-wise career advancement and for collateral education are built into institutional regimes.

WHAT CAN PSYCHIATRIC FACILITIES EXPECT FROM TECHNICIANS?

We believe no single role, or arbitrary collection of specific activities, can be prescribed in detail, a priori, for all institutions and every graduating technician. Evolving community centers, as well as "old-line" hospitals will have to join with their initial technicians, and their faculty and jointly discover bold, new roles appropriate to particular situations.

Institutions and their technicians should delineate a continuum of occupational roles and levels of responsibility cutting across a wide spectrum of intelligence, personal interests and background experience. In the heterogeneity of the technician group there is a wonderful potential for diversity of talents and special skills. If admission standards to the colleges and job classifications remain sufficiently flexible, matching of people to jobs, maximizing both job satisfaction and clinical proficiency, becomes an institutionally feasible goal.

Job assignments should be structured to encourage experimentation in manpower utilization, the accommodation of new service patterns and the inevitable development of individual technician's special capacities. We would hope that the technicians' roles will emerge, existentially, out of an overall institutional context, which, in turn, is inseparable from the total community and the needs of its people.[7]

A REALISTIC APPRAISAL OF INSTITUTIONAL MANPOWER

Technicians, bursting upon the manpower scene, give cause for state systems and other treatment facilities to re-examine their manpower policies and explore the refashioning of professional roles in more exacting conformity to modern, more effective patterns of care delivery.* Agencies and institutions ought to honestly appraise their present professional manpower, not by academic degrees or positions budgeted, but in terms of the actual competence of the real people physically on the job – particulary vis-a-vis vacancies. If their existing personnel are unequal to the challenges at hand, then they should consider establishing a graded series of job assignments "most" of which could be adequately performed by "some" of the soon-to-be-graduating technicians.

Not *every* beginning technician will automatically be suitable for any and all of the designated tasks, but *individual* technicians, qualified and interested in each of the various assignments could be found, and hired, without difficulty. It would be presumptuous of the program to claim the technicians fully trained and ready for random assignment. Preferably, program directors should select individuals carefully, just as they do professional staff, coordinating personal interests with the requirements of the job.

In addition, most institutions should plan to provide inservice education and close supervision over the first year, as specific skills are mastered, clinical judgment refined and institutional routines learned. Much of this supervisory role, however, could in a few years, be delegated to experienced technicians.

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*Parenthetically, the economics of mental health care, at a time of increasing public awareness and demand, creates the paradox of a society unable to pay for levels of services it is simultaneously recommending to itself as an absolute minimum. Ten years' education *preliminary* to professional employment, for the most part training in areas unrelated to the final specialty field, is an inefficiency eliminated through the use of associate professionals who train on-the-job. Wages of our technicians, say, $5925-9417, are a third or less than professional salaries or private practice charges for professional care. This fact may take on paramount importance in the "new society" of equal medical care for all.

INSTITUTIONAL READINESS FOR TECHNICIAN COLLEAGUES

Planning for technicians should begin well in advance of their employment – not so much in terms of what they'll do, but rather of their impact upon the status quo, and of their ability to handle the job being done by existing staff. First, frank and open discussion amongst personnel of all echelons about forthcoming technicians is mandatory. It is true, that their presence as practicum students eliminates much of the fantasy involved, and makes later employment less of an institutional "shock". Who they are, their pay, duties, background and extent of training, requires general dissemination, as well as the more ephemeral issues of their clinical prerogatives, status, (Maryland students, for instance, have never worn uniforms), and relationship to all levels of staff.

Secondly, it is imperative that out of the sum of the professionals' many duties, we separate what is truly a function of graduate professional education and later clinical experience, from the less demanding tasks which could by safely and expeditiously delegated to associate professionals. Such a listing should not only include room for the technicians' professional growth but should also suggest clearly limited parameters for independence of clinical judgment or action, and the supervisory responsibilities of their superiors.

Are technicians worth the trouble? Immediately: no! But, with their increasing numbers and deepening clinical skillfulness over a few years, they stand ready to multiply many-fold our available manpower in the "public sector" of mental health care. Mc Pheeters emphasizes the unlikelihood of technicians displacing anybody; previously "dead-end" non-professionals will move upwards into their ranks, while professionals will finally have a trained manpower pool – the "indians" – for manning otherwise impossible research, service or administrative programs.

MAINTAINING CAREER OPPORTUNITIES FOR TECHNICIANS

Preliminary discussions with several four-year colleges have raised the possibility of parallel four-year programs, similar in basic theme to the technician curriculum, but with the addition of electives, advanced mental health practicum and social science courses, and other general education requirements for the B.S. degree. The advantages to the community college technicians would lie in: (1) full transferability of technician college credits, (2) upward mobility within both their own "career" and the traditional collegiate system; and, (3) serve as stepping-stone to graduate professional school for those so motivated.

Graduates from such a "mental health counselor" curriculum would dovetail with community college technicians gaining promotion to the Technician III level, with a six step salary range of $7,170 to $9,417. Although far from finalized, plans call for Technician III positions within the Department, utilizing both experienced Technician II's and baccalaureate "counselor" graduates, for key supervisory, teaching or specialized clinical duties.

In addition to general personnel prerequisites, promotion from Technician II to III would require collateral in-service or advanced collegiate education. Three, or possibly more, equally acceptable educational pathways are envisioned: (1) advanced on-the-job courses – consistent with standards of professional education – and preferably under joint college-Departmental auspices; or, (2) completion of a specified series of certificate courses in job-related fields to be offered at neighboring community colleges or university medical center complexes; or, (3) a B.S. degree with a major in any of the human behavior fields.

Our wish for the incorporation of "traditional" educational prerequisites for career advancement derives from the associate professional *concept* and its unalterable commitment to eventual full professional skills (and commensurate responsibilities, prestige and pay).

Work experience alone, even for the most talented individuals, in the absence of bona fide professional training, could not guarantee the breath of competence we "expect" of professionals. Although, perhaps, unorthodox in pattern and innovative in its presentation and scheduling, advanced training for the associate professional must be identical with professional school programs in its pedagogical and faculty standards.

To hold these criteria, while making "good" on promises for "open" career ladders, may well demand of the Department the fashioning of appropriate educational vehicles on its own initiative and expense. Work-study programs, allowing employees to pursue full-time study without penalty in income, are needed, too. The technician program cannot succeed in our monolithic instituions, nor would it be democratic, if the Department's "non-professionals" did not have free access. And, unless one were to engage in hypocrisy, "free" access must be measured in truly realistic terms, taking into account family and financial obligations, educational liabilities and more subjective psychological barriers and prejudices as well. (Married psychiatric aides, in their 30's, cannot return to nursing school, for example, on an $1800 Federal fellowship.)

We have tried to avoid the pitfall of creating a program which "dead-ends" below the aspirations or potential of even a small percentage of those recruited. We believe that if personnel are to commit themselves wholeheartedly to a program's therapeutic objectives, in concert with that program's professional leadership, then they must feel deeply included in its mainstream of personnel development; in health institutions, this means sharing in the machinery for professional advancement. Nobody enjoys drudgery; everyone wants to play "his" part. Everyone "needs" the recognition, emanating from higher levels of job mastery, which is, unfortunately, accorded only by upwards progression in the institution's primary hierarchial system. Participation in major decisions of policy, high pay and the assumption of program responsibility, are never entrusted to "the best darn aide in the hospital."[10] Today "he" feels it, and so does every other aide. The youngest "rookie cop" may realistically aspire to the police commissioner's job. We commend this principle and hope someday to see educational programs in the mental health field capable of achieving that goal, but without undermining either orthodox graduate education or violating standards of professional education essential to positions of medical responsibility.

One mechanism might be to build into all in-service programs the educational wherewithal required for entry into *training* for the next higher level. Albeit most people would never apply and others would fail-out during the advanced training, none the less, at least nobody could be excluded from "giving it a try." For example, if admission to R.N. programs requires a high school degree, then "one" aspect of L.P.N. training ought to be sufficient remedial work in general education to assure completion of the high school "equivalency" exam.)

Another proposal has been to inaugurate a different kind of undergraduate third and fourth years for A.A. program graduates leading to a B.S. degree in one of the health disciplines.[22] Philosophically based on the engineering school model, these programs would enable A.A. graduates to transfer, at any time in their careers, to professionally oriented undergraduate curricula, thus, gaining both professional tutelage in the health discipline of their choice and a wider horizon in general education subjects. For those persons unsuited to the rigors of top master's and doctorate programs, requiring independent research, comprehensive mastery of the literature and a written thesis, there would still be possible sound, systematic well-supervised curricula in basic social work, psychiatric nursing, rehabilitation therapy skills, and so on.

Lastly, the Department has initiated a continuing dialogue with the other pertinent State agencies (Correction, Welfare, Health, Education, Probation and Parole, Juvenile Services) in the hope of promoting fluidity of lateral mobility for the technicians. Career opportunities would be significantly enlarged, if relatively consistent minimum educational standards, or even core curricula, could be established at entry levels and at conspicuous higher intervals. While some experienced technicians might be lost to mental health programs, they would still remain in the helping professions; their psychiatric skills would make them particularly valuable. More importantly, finer recruits and individuals would be attracted by the better career prospects for moving upwards or laterally to another agency; they would have a greater opportunity for more fully realizing their own potential, which, after all, is the "name of the game" in our human behavior professions.

ACKNOWLEDGEMENT

Implementation of the technician program has been a team endeavor demanding of the singular talents of many. Within the Department the

special creativity of Dr. Alfred M. Wellner requires mention; Mr. C. Richard Springer directed our personnel efforts and both Dr. James E. Carson, Present Commissioner, and his predecessor, Dr. Isadore Tuerk, afforded guidance and an unfailing commitment to the development of associate professional manpower.

Dr. Paul Johnson, Dean at Catonsville, has provided inspiration and leadership within the academic community. Mr. Joseph Scarlett and Dr. Shabse Kurland, also of Catonsville, Dr. Eveline D. Schulman of Baltimore Community College and Mrs. Priscilla Woolley of Essex were central to the curriculum's development in their respective colleges. And, finally, Dr. Harold Mc Pheeters, and his SREB staff, remain acknowledged godparents to the Maryland programs; we are all indebted to their foresight and perseverance.

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Table No. 1

COMPOSITE CURRICULUM FOR ASSOCIATE OF ARTS DEGREE IN MENTAL HEALTH TECHNOLOGY:

FIRST YEAR

First Semester	**Credits**
English Composition	3
Public Speaking	3
Introductory Psychology	3
Introductory Sociology	3
Humanities	3
Physical Education	1
	16

Second Semester	Credits
Expository Writing	3
Psychology of Personality	3
Contemporary Social Problems	3
*Group Dynamics (MHT 103)	3
*Field Work in Mental Health (MHT 101)	4
Physical Education	1
	17

SUMMER EMPLOYMENT IN A MENTAL HEALTH, WELFARE, ANTI-POVERTY
or similar human services occupation.

SECOND YEAR

First Semester	Credits
Biology	4
Psychology of Exceptionality/ Child & Adolescent Development	3
*Activity Therapies (MHT 104)	3
*Field Work in Mental Health (Institutional)	4
Advanced Social Science Elect.	3
	17

Second Semester	Credits
Anatomy & Physiology	4
Abnormal Psychology	3
Art, Music or Humanities Elec.	3
*Field Work in Mental Health (Community) (MHT 201)	6
	16

*Indicates clinically oriented mental health course, taught primarily in small group subsections within a community mental health or institutional setting.

BRIEF COURSE DESCRIPTIONS FOLLOW FOR THE SPECIALIZED MENTAL HEALTH COURSES

MHT 101-102 FIELD WORK IN MENTAL HEALTH – (4-4); Two hours lecture, Six hours field work each semester. First Semester: Cross-cultural studies on human adaptation; Historical perspectives; Techniques of observation, recording, summarizing and communicating human interaction; Interviewing; Ethical consideration; Mental health roles; Patient roles; Second Semester: Psychosexual development in children; Testing techniques; Group process in various settings; Dynamics of total institutions; FIELD ASSIGNMENTS: Students rotate through three 5-week assignments, first semester; two 9-week assignments, second semester.

MHT 103 GROUP DYNAMICS (3): Two hours lecture, Two hours small group labs. Factors involved in group cohesion and conflict; Communication systems; Role functions within groups; Individual sensitivity and self-awareness; Affective interrelationships; Role playing; Psychodrama and Sociodrama. The small group studies itself, communication and sensitivity skills are practiced.

MHT 104 ACTIVITY THERAPIES (3): Three hours lecture, 1½ hours laboratory. Within a context of milieu therapy and group social interaction, elementary techniques of the several activity therapies are taught. Activity therapy programs of the participating agencies serve as demonstration models and practice sites.

MHT 210 FIELD WORK IN MENTAL HEALTH (6): Two hours lecture, 12-15 hours field work/week. Community organization; Deviant behavior as a function of culture; Availability of social mechanisms in support pf psychic equilibrium;Alienation; Community agencies in theory and practice; Delinquency; Alcoholism and narcotics; Retardation; Social class structure, education, vocational skills, family relationships, stress, somatic disease and self-image as factors in the emergence of overt symptomatology; Principles of transference, over-identification, denial and projection are explained. FIELD ASSIGNMENT: 18 weeks, two days each week to a single community mental health facility; beginning clinical work under close supervision; works as responsible member of mental health team with individuals, families and in consultation to larger groups.

THE NEW CAREERS PROGRAM

By Jacob R. Fishman, M.D.

Jacob R. Fishman, M.D., is Director of the Center for Mental Health at Howard University in Washington, D.C.

He is keenly involved in the development of new careers in human (public) services. The New Careers program is structured around the development of new jobs, training, employment and careers at the intermediary professional levels. While particularly aimed at assisting disadvantaged populations to help themselves, the concept is also concerned with meeting needs for trained personnel and improving services in the fields of health, public education, social service, law enforcement and public safety, child care, and community developments. Experimental projects have demonstrated the New Careers program concept to be uniquely effective in its impact on participants, on those being served, and on community improvement.

Dr. Fishman has worked on projects in New Careers under the sponsorship of the Department of Labor, Manpower Administration, Bureau of Work-Training Programs. He has presented his concepts jointly with others in such publications as "Procedural Guide for Program Development in New Careers." "New Careers Position Descriptions, A Sourcebook for Trainers," and "Training for New Careers."

At a time of severe shortages in health manpower, the concept of new and attractive careers that permit the individual to advance upward on a career ladder offers a valuable contribution for resolving these chronic problems. It is a concept of great value to psychiatric technicians who themselves are seeking ways to advance in their careers in order to make a greater contribution to the urgent needs of mental health.

Instead of covering the same ground that you've already covered at this meeting, let me turn it around and spend just a few minutes commenting on some of the things that you've heard yesterday and today. I think you deserve some critical reflections on what has been presented to you.

It's a compliment to your leadership that they've put together a bold and imaginative program at this meeting that focuses so sharply on the issues of career development, education, training, and methods for carving out deserved recognition, roles and responsibilities for the psychiatric, or what I prefer to call, the mental health technician, and other intermediary level professionals.

For the last few years at Howard University in Washington and in several other places we have been experimenting with redefining and upgrading the role of intermediary level people working in the fields of mental health. We have been trying not only to find the kinds of things that intermediary level personnel can do as well or better than people who are trained to do other things, but also to find ways to attract more people into the field. We have been trying to make of the field a career opportunity which as Dr. Vidaver has already said will "both motivate and hold people" as it does in education and in many other fields of human services.

We have done this not only in mental health but in many other human service fields. We have done it on many different levels, both at the entry and the more specialized levels. At the entry levels, it has involved recent high school graduates, unemployed or underemployed, who can be trained and placed in new kinds of mental health programs. On a more specialized level, it consists of finding ways of training and upgrading people so that they can attain accreditation, certification, and advancement to higher levels of supervision, more specialized treatment and diagnostic work, and community outreach.

We have also experimented with introducing these programs within the senior year of high school. Here we offer a combination diploma program and mental health or health training program. The students get a training stipend and spend part of the day training with a combination of seminars, practicum experience, work in the community and training for an intermediary role in a program. They graduate with a diploma as well as a certificate and move directly into a full-time job in a health or mental health agency. This has been quite successful. We have also been trying to construct a model very similar to the other models that you've heard about this weekend in which a person could move up the ladder through a combination of work and training.

But now that you have heard for the last two days how wonderful it is to be a psychiatric technician let's turn it around for a minute and talk about the problems of the technician. You and I know how difficult the real situation is. We are aware of the existing rigidities of the system, and know that there is nothing that can be quite so rigid as a good old state civil service system — unless it's the federal system.

The problem in mental health and community mental health involves the manner in which crucial decisions are made on patient treatment. The administrator and the psychiatrist come in and out very quickly. They decide what drug is going to be used, when the patient is ready for discharge, and what the overall budget of the hospital is going to be. But beyond these decisions it's really the people in the units and in the programs who make all the crucial decisions about what happens to the patient and how the patient gets treated. Now the only problem with this whole system is that you know it and I know it, but neither the nurses, the psychologists, the psychiatrists, or the hospital administrators know it. They may say occasionally, to make you feel good, "We couldn't run this ward without you. You're really terrific. We depend on you." But they don't really accept that. And the problem connected with that is that even when they do recognize it, the institutional structure doesn't recognize it.

Let's talk about that problem a little more. Here you sit on the threshold I hope of major new national organization that will try to organize, develop standards for, and build a program for intermediary mental health personnel. This is desperately needed in the country today. There is a marvelous opportunity to make a truly national movement out of it just as the psychiatrists, the nurses, the psychologists, have done it before you and have done it to their great benefit, as well as to mental health's benefit. You need that now. You will find many, many allies all over the country who will be willing to help.

But you must recognize that, in doing this, you will have to take on a number of major issues that have to be thought through and worked through. One of them is how you can develop a workable, effective system of standards for entry level training that will upgrade the programs by upgrading the skills of people coming into the program.

Your argument is sound if you say that by upgrading the standards and the work of the intermediary personnel, you're improving the system. Improving the system must be the major thrust. If you want to improve the system the only way of doing it is by improving the standards of the people who spend most of their time with patients.

Civil service and the civil service structure are a major issue here. How do you develop a career ladder that allows, supports, and facilitates, entry level employment and also provides training and experience that can readily help a person move from the first level to the next level and beyond. In doing this you have to cope with some of the old civil service ghosts, which were originally developed to protect people and guard against patronage, but now have become somewhat outmoded in our system. The major ghost is the idea that there are specific narrow categories of personnel and each job exists in itself without regard for the next higher job. For example to change from being a nursing assistant to a nurse takes a major act and several years of fulltime schooling to relearn much of what a person already knows. It means that the student must assume a completely different role which in actuality involves nine-tenths of the same tasks he was doing when he was an aide.

The nurses don't like to hear this. Neither does the doctor like to hear that what you are doing on the ward in many ways overlaps what he was doing. Of course the point is that he's overtrained to do many of the things that he spends his time doing that you could do better. That's not to pat you on the back. That's to point up a major problem: the very inefficient manpower utilization that currently goes on in our institutions.

Civil service has to be shown that by developing these career ladders you decrease turnover. By doing that you create a huge savings for the system because large personnel turnovers represent huge amounts of wasted money. Secondly, good career ladders mean you wind up upgrading the skills of people who are lower down on the ladder and it gives you a much more effective cost-efficiency ratio. That's an impressive phrase of great improtance to state planners and controllers. You have to get them on your side if you want to win this battle, because that's ultimately where the big decisions are made. Thirdly, by upgrading you increase the standards of care and hopefully again you increase the cost-efficiency ratio because patients get helped sooner and get out quicker, particularly if you begin to develop roles that include community outreach and followup.

In the civil service system another major block for the technologist is the nursing series. Now excuse me for saying it but, although you've heard me very carefully use the word mental health technologist and intermediary role, you and I know that from the point of view of many hospital staff personnel this role is usually known as an orderly, a nursing assistant or a psychiatric aide.

Even though we're changing the name of the game, much of the resistances have to do with the old image of the manner in which such personnel are utilized, particularly since in the traditional hospital structure it is the nurse who supervises.

In fact the nurse, not the doctor, runs the program.

One of the things that nurses guard very jealously, and I presume it's the same in California as it is elsewhere, is that empire and the people in it who work for them. I'm not criticizing nurses; I'm just talking about what I think of the facts of institutional life.

One of the problems with that structure is that it's built into the civil service generally. It is built into the job descriptions of the nurse and the nursing series. The supervision of all nursing personnel, and frequently of the aide, the orderly, the nursing assistant, the technician, and the mental health assistant, is under the supervision of that series.

That also means that, because of the nature of the civil service, advancement is limited by the position the registered nurse holds in the nursing series. To overcome this limitation you have to begin to develop alternatives to this structure: Parallel lines of advancement around the nursing series.

In Washington we have a series that begins with mental health aide then goes on to mental health assistant, associate, and technician. These people are supervised either by others at the level above them or by professionals in other categories, such as social workers, psychologists, psychiatrists, and recreational and occupational therpists. To accomplish this took a major effort. We weren't successful in rescuing the nursing assistants from nursing supervision.

My experience with most of the cities and states in this country is exactly the same. The development of career ladder programs is generally a problem. It gets compounded because the laws in many cases certify only the licensed practical nurse and the registered nurse, and the other people have no status. The legislative lobbyists keep them down. To overcome such generally widespread problems I emphasize and reemphasize the need to develop alternate career lines. Fortunately there is increasing concern for this whole issue and greater possibilities for support.

There is another point that should be emphasized. The rapid expansion of the community mental health movement into a community has opened the door for the development of new roles, new career ladders and new advancement series in which the nurse suddenly finds herself without the traditional role. A number of approaches are possible to career development programs in which nursing care is just one of many. Under these conditions, one can develop a mental health intermediary structure that has as a generic base level, the mental health aide.

From this level there are a number of series steps in the different specialized fields of mental health for advancement to the assistant, associate and technician levels through appropriate training and experience. These specialized fields are in recreation therapy, social service care, group therapy, case finding, case expediting, screening and followup, community outreach, child, adolescent and adult work, drug addiction and alcoholism.

To repeat, although the situation may still be very rigid in the state hospitals, the movement toward community health has made the organization and structure of mental health programs for the next 5 to 10 years a wide-open issue. The people that you may think of as the big experts haven't the foggiest idea of how to effectively structure a community mental health program to meet the needs of the community.

We're just beginning to learn and it involves issues of relationship and community and definition that you know as much about as many of the professionals who've spent years and years behind four walls of a ward. We're groping, we're finding our way. One thing is very obvious; it's wide-open. We have to define the roles, and how manpower is going to be utilized.

I'll tell you another fact of life which we don't like to admit. Despite the talk of AMA, the nurses and the social workers about a rapid increase in professional training programs in this country, there is no possibility of increasing professional training to even keep up with the current manpower gap, that exists in all these fields. The handwriting is verly clearly on the wall. We have to open up and change the entire structure of manpower categories and manpower utilization. The entire structure will have to depend very heavily on the utilization of intermediary level personnel and beginning level personnel.

There is a vivid illustration of this point in my own experience. We received 3 million dollars for a community mental health program for an urban area of Washington, D.C. and some 7 or 8 million dollars for other programs in other parts of Washington, D.C. These programs were abundantly provided with social workers positions, nurse positions and psychiatrist positions. With such generous funding we had no doubts about filling these positions and doing all the things we had planned.

Well we found that there just aren't personnel available at this level. So one by one we had to change these positions and redefine them for intermediary levels and for entry levels. Where we had a psychiatrist we had to put in two or three aides, or assistants. We couldn't fill the nurse positions. Mental health and health programs throughout the country now all have large numbers of vacancies at the professional level. We're still playing games with that. That means we're still keeping those vacancies on and we're using the money in other ways. But the situation is rapidly catching up and those positions will have to be redefined and restructured for other levels.

Unless you follow through on what seems to be the intention of this organization, from what I've heard at this meeting, events are going to pass you by. The pressures are so great.

You have an opportunity of really getting on top of this field at the critical time. You have an opportunity to develop standards, career ladders, training programs, and to gain influence and play a role and have a voice in nationwide policy making and planning. However, you may have problems doing it on the individual hospital level now because of the structure. You may even have problems at a state level now for reasons which I will not go into. But even though you may be having these problems at the local and state level, the national trend is such that by assuming national leadership through this organization you can significantly influence national policy just as the psychologists, psychiatrists and nurses did. Through such national leadership you can then influence and bring pressure to bear on the states and the individual programs. This technique has been quite successful for other fields.

I have to warn you, you better do it fast or it isn't going to happen. You're going to get lost in this thing. For example people are talking very glibly about these great associate of art programs. But I don't know how many people in this audience have an associate of arts degree. If you used the existing models generally for getting such a degree, all of you would either have to go to school at night or leave work and go to school, There are very few programs in this country that offer some realistic and meaningful alternatives.

The realistic and meaningful alternatives in achieving professional upgrading can be listed very quickly. Number 1, civil service, or the job structure in an individual agency, has to accept and implement the principle of tying promotions to training achievements, and accreditations. There is little in getting an A.A. degree if it means that you will get only two or three hundred dollars more a year, and would not have an opportunity for increased responsibility. Number 2, the institution should provide release time for a full time employee to get training because such training directly benefits the institution. You may have to convince the hospital director that it's in the institution's interest to do this because he's worried about his budget and about his ward coverage. There should also be built into the system the development of practicum and supervised on-the-job training for which you are paid. The community college should give you credit toward the degree for such insitutional training. We were successful in putting this vital principle into effect at a few places, but it was not easy. Number 3, you must convince the community colleges and extension programs that accredited training can be given at places other than a classroom on the college campus. It may be no problem to get to a college classroom if you happen to live in a small town and the community college is right there. But if you have to go across San Francisco or across New York it's quite a problem. Finally, it's extremely important for civil service and the community college to accept your experience for credit toward the degree. It makes absolutely no sense to be told by the college establishment that it cannot give you credit for what you have already learned through your job experiences, because it wasn't done under the supervision of a duly accredited professor. It's uneconomical for the system and it's an unnecessary and almost impossible burden for you.

The same transferability of credit should apply also for the bachelor's degree. We must not only develop mental health sequences at the AA level and at the bachelor's level, we must also link the institution that employs you with the educational institution so that the two can develop a coherent program that meets everybody's needs. The education system, tied as it is to the concepts of liberal arts education, doesn't like to recognize something called training. They consider it too vocational, and somehow vocational training has been degraded in our system. This bias must be overcome. The institution that employs people and has manpower needs and the educational institution that gives courses must jointly develop a curriculum that meets not only both their needs but meets your particular needs. By meeting your needs it will also meet the needs of the client population that is being serviced by these programs.

We must above all have goals that are real and practical for the man on the bottom. The ultimate goal that we have to work toward is a career ladder from high school on up that is linked to job opportunities and that allows a person to move ahead according to his motivation and capability. It is a career ladder that utilizes job experience as an important rung of that ladder, and allows a person to make a living while he is getting the necessary training and experience. This is the best way to learn.

Dr. Vidaver in his presentations to the institute pointed out that a doctor goes to school 12 or 15 years before he even sees a patient. You know that does not make sense. When he finally sees a patient he has to be trained all over again in working with people in a clinical setting. Perhaps there is a more rational way of doing things and I challenge you in this organization to look for new ways and to try to experiment with them. You should make your voice heard along with the voices of all of the other organizations and professional associations which have had a monopoly in this matter, largely because of the vacuum.

I must point out that this change in educational procedures is not going to happen very quickly. It may take several years, mabe even 10 years, to restructure everything, because once a structure gets set up, many people will fight to the death to keep it that way.

It is only in the last 40 to 50 years that this country has begun to develop this kind of rigid over-professionalization of services manifested by rigid standards and a hierarchy of degrees. Although in general it has served to improve the standards of care, it has in a sense also become dysfunctional; we find ourselves at a point where it is a block instead of a help. At any rate it's going to take a long time to change this, and you should establish this as one of your organization's goals.

I think that some of these goals have to be set forth in a statement of goals and values, and in a program for mental health from the point of view of the intermediary level professional. Your goals and values should reflect what you believe mental health should do in this country through its various agencies and programs. You should actively push for implementation of your program with the support of key national and state groups. Many groups will be very receptive to this.

A good deal of federal legislation has been passed during the last two years in the area of new careers, but not in mental health. A recent amendment to the elementary and secondary school act authorizes the development of career ladders and provides for funding training programs in coordination with the community colleges. Hundreds of millions of dollars are involved for developing these intermediary levels in education in the public schools. Similar legislation has been passed for programs in vocational rehabilitation, in vocational education, child care and Head Start, as well as for programs in regional health.

There is also a bill with which I have been particularly active. It was passed through the Economic Opportunity Act, which is now being administered by the Department of Labor, and is called The New Careers Program.

The program calls for a large number of demonstration programs in various parts of the country to train intermediary level personnel, develop the career ladders for them, upgrade them, and develop linkages with community colleges and universities. It involves a fund of 150 million dollars and 150 projects in various parts of the country. The program is not specifically in mental health but includes a wide range of human services. Mental health is not infrequently included in some of these packages in some programs, but the primary areas are education, recreation, law enforcement, health, and child care. There is nothing specifically in mental health.

I testified at the House and Senate hearings on the new amendments to the Community Mental Health Act last year; I stressed the urgent need for the development of these standards and programs, particularly since new money was forthcoming in community mental health for drug addiction, retardation and alcoholism. It was an opportune time to build this in. I found them quite receptive although they didn't accept an amendment this year.

Your organization should be pushing legislation in this next Congress and the Congress after it to develop these standards and to get money for these various programs. You'll find NIMH, the National Institute of Mental Health, very receptive. Many congressmen and senators are very receptive because they've seen the need.

You've heard a procession this weekend of academic-administrative types who are fairly secure in their own positions. They already have the Ph.D. and the M.D. as well as the academic positions, and some control over money. But they will not be able to do everything that I have been talking about. An organization such as yours will have to do it or it isn't going to happen. I know enough about politics and professionals and human service and mental health in this country to be quite certain about this: It's not going to happen.

We will develop our precious little programs and publish our papers and journals and get invited to speak at meetings and say what a nice thing it is and we'll have our little hot house programs for people to visit. We will get a good amount of glory. People will say what a good job he's doing and how really innovative and inventive he is. But it isn't going to happen in terms of the present system, unless an organization such as yours develops and pushes its goals, develops a system of looking at things and becomes a strong, active advocate of these things nationally, as well as locally.

If you're interested in this field as a career for yourself and others, if you think you're making a contribution to the field, if you think that what you're doing as as important as many other things that are being done in the field, and, above all, if you feel that mental health, psychiatry, and your activities really do help patients, then, I urge you to really get on your horses and begin moving in this direction. Thank you.

COMMUNITY MENTAL HEALTH MANPOWER NEEDS

by Mrs. Sylvia Marshall

Mrs. Sylvia Marshall is a member of the Executive Committee of the Health Manpower Council of California. This is a volunteer organization of community leaders from all areas of California, working to assure an adequate supply of trained manpower for California's health programs. Mrs. Marshall is deeply involved in the mental health manpower deficit that the developing community mental health programs have brought into sharper focus.

Mrs. Marshall, a native New Yorker, is a graduate of Columbia University. She has been active as a volunteer community organizer for the past thirty-six years. Since coming to California in 1953 she has worked as a volunteer in mental health activities. She has served as past president of the San Fernando Valley Mental Health Association, past vice president and present member of the board of governors of the Mental Health Association of Los Angeles, and of the California Association for Mental Health, and is a founder and board member of the San Fernando Valley Child Guidance Clinic.

As a member of the Executive Committee of the Health Manpower Council of California she worked closely with the staff of the California Society of Psychiatric Technicians on a Task Group on Mental Health Manpower. The Task Group established a one-day Mental Health Manpower Conference in Sacramento in September 1968 to discuss the major mental health manpower problems and to recommend possible approaches for resolving them.

It is indeed a special honor and privilege to be invited to speak to you today — but I must first state my own personal reservations about this invitation, other than my lack of professional background. I'll tell you about some things that have been happening in California that could very possibly happen anywhere else in the country — and maybe are. But if, during the course of my talk, I see a head nod in agreement, an ear perk up, or an eye open wider, I will feel rewarded for my efforts — and we all need a certain amount of gratification from what we do.

As a matter of fact, there is no better time than right now to tell you that I, as a consumer of health services and a volunteer community organization person within the mental health movement, have gained a new insight over the past few months and with it a new respect and admiration for you, and your profession. You are a very special kind of person, with dedication, knowledge and versatility – talents that should be skillfully utilized in cooperation with other mental health professionals. But most of all, what you have to offer and what you give to the mentally ill person is a rare and valued commodity that is a combination of energy, patience, sensitivity, know-how, empathy and love; it is a rare combination indeed on today's labor market.

My husband, who, incidentally, is a psychiatrist, once built a large brick barbecue in our backyard in Topeka, Kansas, and when he finished it, after a couple of months of Sundays, he said, "Boy, I've sure got a lot of respect for bricklayers." And that's how I feel about psychiatric technicians, even though I don't ever try to do your job. The more I learn and the more of you I meet, the higher my esteem. But I'm still rather glad I'm not like the little boy who every week used to watch his mother bake and decorate a most luscious chocolate cake to take to the patients in the State Hospital. When the boy went to school and was asked what he wanted to be when he grew up, he answered, without a moment's hesitation, "a patient in a State Hospital."

Since I am here today as a member of the Health Manpower Council of California, I think it appropriate that I tell you a little about the Council. It is a voluntary agency, formed in May 1967, as an outgrowth of two health manpower conferences – one in Santa Barbara and one in San Diego. The conferences, and then the permanent Council, were sponsored originally by Dr. Lester Breslow, the then Director, California State Department of Public Health, the California Hospital Association, the California Medical Association, the State dental societies, the California Nurses' Association and other agencies and associations in allied health fields.

The Health Manpower Council's 25 members are doctors, hospital administrators, and representatives of allied health organizations, medical, educationl and training institutions, labor and consumer interests. These people have banded together in a statewide effort to tackle the complex problem of providing adequate health manpower for the expanding health needs of Californians. The Council's committees consult with junior college curriculum people, and with the private and public hospitals and health plans in an effort to step up recruitment, revise training and educational requirements, and assess the supply and demand factors in the entire health field. They also serve as a clearinghouse for information.

Last May, the CSPT and the CNA requested the Health Manpower Council to assist in sponsoring a meeting of representatives of various organizations and agencies in order to explore together the opportunities available in community mental health agencies for utilizing existing mental health workers.

The request was granted, and Mr. Donald Page, Chief of Employment Services of the State Department of Employment, and myself were appointed to function on a Task Force to plan the inter-agency conference, along with three representatives from the CNA and three from CSPT (your own Bill Grimm, Zoltan Fuzessery and Babette Scott). We got right down to business and agreed on a formal statement of objectives of the conference, and I'll read it to you:

"To explore the creative utilization and training of mental health workers in community programs, with primary emphasis on the middle level, non-administrative personnel involved in mental health education and direct care, treatment and rehabilitation of the mentally ill, the emotionally disturbed and the mentally retarded; and to recommend appropriate action."

We then attempted to assess the statewide interest in these objectives. To accomplish this, we devised and mailed a four-page questionnaire to a select list of public and private agencies, hospitals, nursing homes, educational and training institutions and professional associations. The replies to our questionnaire were thoughtful and challenging, raising many issues and problems from many different angles. We then used the replies as the basic content outline of our conference program. We found in studying the returned questionnaires that the issues divided themselves into four main categories, and we designed our buzz groups or workshops around those four major issues:

1. Innovative uses of existing mental health workers and establishment of new categories.

2. Training and retraining of personnel for community mental health programs.

3. Statewide standards and salaries – uniformity or flexibility?

4. New legislation as it affects mental health manpower supply and demand.

Whatever else the Task Force wanted included in the Conference we covered by means of a morning discussion panel and a luncheon speaker. But I don't want to dwell on the mechanics of putting together a meaningful conference – you people do a very fine job. I do want, however, to report that about 135 people attended, out of an invited list of about 175, which is a fairly high percentage of any invitational list. The cross-representation was just what we had hoped to get – people from State and County agencies, associations, hospitals and nursing homes, educational and training institutions and individual professionals.

We limited our buzz groups to no more than 20 participants, by forming duplicate groups on the same subject when two of them were over-subscribed. This amount of attention to detail gave Zoltan Fuzessery a few more headaches than he needed, because of a sizeable last day registration, but he was more than equal to the task and things ran rather smoothly.

But what went on in those buzz groups was truly fascinating. When these people met, they *really communicated.* We had statements and challenges to the morning panel, and those who wanted to took pot shots at representatives of the State and County Departments of Mental Health, Personnel and Licensing and they returned the fire. But I don't mean to infer that it was all heat and no light. We had an information-exchange day, the dynamics of which were exciting and meaningful.

We picked up information about programs being carried on in various localities in the State, and we heard ideas for creative programs that were being written into budgets for next year. We learned, for example, of psychiatric technicians being used as rehabilitation workers in a day care center in Fresno; of their being included as members of crisis-intervention mobile teams in Los Angeles; of possibilities of utilizing them as resident managers of half-way houses, and as aides to psychiatrists in private or clinic practice; and of many other newer approaches in personnel utilization.

We discussed and made recommendations for changes in training curriculum both in schools and on the job, in hospitals and community programs.

We talked of developing incentives by possibly adding fees for special services to the salary schedules, and of revising personnel classifications for more flexible use of manpower.

But most of all, as I said, we communicated. The tape recorder was left on, inadvertently, in one buzz group, after it was concluded, and I found listening to the conversations there most fascinating. People were exchanging professional cards and phone numbers; they were offering to be of help to each other. This, for me, was one of the real values of the whole day, and the months of pre-planning, the inter-action and talent-exchange of people with the same goals in mind: the maximum use of trained manpower for the benefit of the mentally ill or emotionally disturbed person in our communities. Dr. Peal summarized the basic needs most succinctly at the conference when he said, "What the mentally ill need is not programs but people."

I urge you, on the basis of the benefits that derived from our Conference and from my background and experience as a volunteer community organizer, to think about doing something similar to what we did, in your own community. You don't necessarily have to do it in the same way, of course, or with exactly the same components. But wherever you are, in a big or small community, the need for cross-agency communication exists, and the dynamics of such inter-agency exchange, in one place, at one time, should not be underestimated.

take the leadership role. You have prestige and you have purpose, so put them to good use by taking the lead and alerting the staffs of mental health agencies to your availability and willingness and talents. Start the wheels in their heads going with ways to use the psych techs in programs to help the emotionally disturbed and mentally ill in your community.

We know there are mental health manpower shortages. Some figures are available, but we mustn't get hung up on the numbers game. It is difficult to estimate what the needs will be with this *new* revolution in mental health. We know that people like yourselves, when you become dissatisfied with your job or insecure about its future, often change to some other occupation outside the mental health field completely. For example, Bill Grimm tells me that over 1500 trained psychiatric technicians left the mental hygiene field for other employment during the staff cut-backs in the California Department of Mental Hygiene under Governor Reagan, because there was no plan to conserve and utilize this source of manpower in the projected expansion of community mental health programs. To me, that is a tragic loss and waste of hard-to-find talent.

Therefore, at the risk of being repetitious, I would emphasize that there must be advance planning for the changes in mental health needs. The key to such planning should be the involvement of individuals and agencies of many different levels of interest and responsibility. Many challenging ideas will be developing, and you can stimulate and nurture their growth in your localities by bringing people together to *talk.*

The entire field of training for indigenous non-professionals is a fairly new program in California. I am sure you have received much valuable information about it at this convention-institute. Some thought must be given as to how you people with hundreds of hours of training and years of practical work in your profession can be utilized in relation to the new young workers coming out of the poverty areas of our bigger cities.

The simultaneous launching of the federal community mental health center and the anti-poverty program was not at all coincidental. There is, as you well know, a big drive to recruit young people from the deprived areas into the health fields, and particularly mental health. In Southern California mental health aides are being trained for use in a variety of ways. They serve as "patient advocates" or liaison between the patient and the community agency, and as case aides to develop patient histories in day clinics. Housewives whose children have grown up are being used as mental health workers in day treatment programs.

It would seem to me that you could explore with the directors and staff of these special programs ways in which you could assist in training some of these new recruits to mental health. With your professional background and practical experience you could "tell it like it is" in handling some of the behavioral difficulties they are likely to encouter as they take on more responsibilities. And in turn, of course, there is a great deal that you psych techs could learn about community resources, family interaction and home environmental problems.

Innovative ideas and creative planning are tired words, but new careers for the poor and the use of indigenous non-professionals are very much in the minds and thoughts of our community planners, as you must have realized by today. So I say to you middle-level professionals, put your ear to the ground in your community, find out what is happening, and "get with it", so that you are in on the planning and can use your skills and those of your association members wherever possible.

FUTURE PUBLICATIONS

The National Association of Psychiatric Technology plans to publish in the future similar presentations of its annual convention-institutes. The plan is to initiate a quarterly professional journal for middle level professionals in psychiatric and mental health technology. Such a journal would include convention-institute presentations. We believe that there is an urgent need for such a publication and that our National Association should develop one.

There is much information for middle level mental health professionals scattered through many periodicals. It would help to channel such information to a single publication that would be geared to the operational levels of care, treatment and rehabilitiation of the mentally ill, the emotionally disturbed and the mentally retarded, as well as to educational and preventive programs in mental health.

Such a publication would offer the technician new insights into established practice and aid in the evaluation of new techniques and procedures. It is anticipated that such a journal would include detailed information on techniques in behavior modification, remotivation, psychodrama and sociodrama, community activity programs, new roles for mental health workers, new training programs and career structures, as well as the proceedings of seminars, conferences and workshops.

To make possible such a necessary venture, the Association needs the support of the professional and the middle level professional in mental health. We invite you to submit your papers on programs in psychiatric and mental health

technology, as well as your suggestions as to the format and substance for such a quarterly journal.

Remember, if you believe that a professional journal for middle level professionals in mental health is necessary to coordinate your efforts and to serve as a clearing house for information and programs of interest to you, then we ask for your full commitment to such a venture. Get involved and contact the National Association of Psychiatric Technology, 1127 - 11th Street, (Main Floor) Sacramento, California 95814.

ABOUT OUR ASSOCIATION

The National Association of Psychiatric Technology, a non-profit organization, is the logical outgrowth of local and state organizations of psychiatric attendants, aides and technicians who had banded together to improve their knowledge and skills and to demonstrate their competence to assume greater responsibilities in the care and treatment of the patients in the state hospitals for the mentally ill. The present National Association was sponsored by one of such state associations, the California Society of Psychiatric Technicians.

The California Society was established as early as 1950 by a group of hospital attendants who recognized the need for representation and eventual professionalization. It was in 1951 that the group decided upon the designation "psychiatric technician."

The changes that have affected the entire field of mental health care have brought new roles and responsibilities to the psychiatric technician. His custodial functions to care for the patient's physical needs and to ameliorate his psychological problems proved too narrow for the new goals of rehabilitation. The technician became part of a therapeutic team that worked to bring the patient to a more normal living in the community. His functions are continuing to change as his opportunities for serving the mentally ill, the emotionally disturbed and the mentally retarded are shifting from the institutional to the local community settings. His training has become more extensive to prepare him for participation in innovative treatment and rehabilitiation programs that are based upon the psycho-social sciences. He has assumed new designations as his role and educational base changed; most often his new designation is mental health technician or assistant. He has become the middle level professional in mental health that is so sorely needed in this period of acute manpower shortages that affects the entire field of health.

The National Association of Psychiatric Technology has as its objective to foster the logical advancement of the middle level professional in mental health, through the development of open-ended career ladders and educational programs that permit entry to all individuals who can and are willing to help the mentally ill. The Association believes the best interests of mental health are served by careers that allow upward and lateral mobility. The Association seeks to obtain legal and professional recognition, including licensure, for the middle level professional to permit him to make the best contribution to mental health. It invites all psychiatric aides and technicians, mental health technicians and assistants as well as individuals in other disciplines who are engaged in treatment and rehabilitation of the mentally ill, the emotionally disturbed or the mentally retarded to join the National Association of Psychiatric Technology and assist it in advancing these goals. Membership dues are $12 a year. Organizations and agencies are also invited to contribute to this effort. For further information and application for membership please complete and mail the attached form to the National Association of Psychiatric Technology. The Association publishes a monthly newsletter, ESPRIT, which is sent to its members. Additional copies of this book can be purchased at $1.75 a copy by returning the coupon below. Please make your check payable to The National Association of Psychiatric Technology.

NATIONAL ASSOCIATION OF PSYCHIATRIC TECHNOLOGY
1127 – 11th STREET, SACRAMENTO, CALIFORNIA 95814

Name
(Last) (First) (Middle)

Organization or Agency

Address

City **State** **Zip Code**

- ☐ Please send me application form(s) for NAPT membership
- ☐ Please direct me to my state's psychiatric technician association
- ☐ I would like information on forming a state psychiatric technicians association
- ☐ Please send copy(s) at $1.75 each of "Community Mental Health and the Psychiatric Technician." My check is enclosed.